MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 174

CERTIFICATE OF DEATH

01200

Reg. Dist. No. 8

1. PLACE OF DEATH:
County: Allegany
City or town: Klondyke
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 14 yr. 7 Mos. 18 days
Hospital, institution, or street address where death occurred: —
How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Klondyke
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME: Arthur Paul Baker

3.(b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: —
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 30, 1930.

8. AGE: Years 14 | Months 7 | Days 18 | If less than one day ... hrs. ... min.

9. Birthplace: Klondyke, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation: School Boy

11. Industry or business: Beall School - Boarding

FATHER
12. Name: Arthur Joseph Baker
13. Birthplace: Mt. Savage, Md.

MOTHER
14. Maiden name: Elizabeth Burgosh
15. Birthplace: Austria, Hungary

16. Informant: Mrs. Arthur Baker
Address: Klondyke, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 21, 1945 (month) (day) (year)
Cemetery or crematory: Mt. Savage Cemetery
Location: Mt. Savage, Md.

18. Funeral director: Mr. Eichhorn
Address: Lonaconing, Md.

19: Feb. 20, 1945 (Date rec'd by registrar) Dr. E. J. Bowman Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: February 18th, 1945, at 1 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

	DURATION
Immediate cause of death: Crushed head and chest (frac. both legs and left arm)	killed instantly.
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: 2-18-45
Where did injury occur? Klondike, (City or town) Allegany, (County) Md. (State)
Injured at home, farm, industry, public place (where?): mine
Means of injury: fall of rock Injured at work? yes

23. SIGNATURE: Prince H. Brown, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 2-19-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

61201

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? Three Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 416 FAYETTE AT.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME C. WOOD BEACHY [Clarence Woodward Beachy]

3.(b) Social Security Number [illegible]-57-0241290

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	DIVORCED

6.(b) Name of husband or wife EDITH NAUGHTON
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) JAN. 19 1877

8. AGE: Years	Months	Days	If less than one day hrs.	min.
68	1	2		

9. Birthplace Salisbury, Pa.
(Town, county, and state)
10. Usual occupation Dentist
11. Industry or business Own Business
FATHER 12. Name Gideon J. BEACHY
13. Birthplace Grantsville Md.
MOTHER 14. Maiden name EMMA NEFF
15. Birthplace Pa.
16. Informant Mrs Walter Orr
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23 45 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein Inc.
Address Cumberland.
19. Feb 23 1945 (Date rec'd by registrar) Winter R. Beachy M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 21 1945 at 8:45A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from I. 2. 1941 to 2. 21. 1945 and that I last saw him alive on 2. 20. 1945

Immediate cause of death	DURATION
Chronic Nephritis & Hypertension (uremia)	
Due to Chronic Myocardial	
Due to Heart Disease	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jno. F. Williams M. D. or other
Address Cumberland Date signed 2-24-45

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

012?2

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town BARTON,
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME MR. JOSEPH BEAN

3.(b) Social Security Number 216-07-2335

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	SINGLE

6.(b) Name of husband or wife
8.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 26, 1892

8. AGE: Years	Months	Days	If less than one day
52	7	28	hrs. min.

9. Birthplace W. VA. (Town, county, and state)
10. Usual occupation CONSTRUCTION WORKER
11. Industry or business W. Va. Pulp and Paper Co.

FATHER
12. Name JOHN BEAN
13. Birthplace MD.

MOTHER
14. Maiden name SARAH BARNHILL
15. Birthplace MD.

18. Informant SELF - ON ADMISSION
Address to hospital

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28, 1945 (month) (day) (year)
Cemetery or crematory Ft. Sahale
Location Barton, Md.
18. Funeral director Ellsworth S. Beall
Address Westernport Md

19. Feb 28 1945 Winter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 24 1945, at 7:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 4 1945 to Feb 24 1945 and that I last saw him alive on Feb 24 1945

Immediate cause of death	DURATION
Acute Myocardial dilitation,	1
Due to pulmonary oedema	1
Due to following Coloboma	4 days
Due to for adeno carcinoma of	?
Other conditions rectum	

(Include pregnancy within 3 months of death)

Major findings of operations Carcinoma rectum
Date of op. 2-20-45
Autopsy results carcinoma rectum
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE F. Milton Jr. M. D. or other
Address Lonaconing Md Date signed 2-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

01203

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 yrs

Hospital, institution, or street address where death occurred: 324 Furnace St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 324 Furnace St

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME George Fred Beck

3. (b) Social Security Number None

4. Sex	5. Color or race	6. (a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Annie M. Paul

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 4 1864

8. AGE:

Years	Months	Days	If less than one day
80	10	2	..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Restaurant Keeper.

11. Industry or business: Proop.

FATHER

12. Name: Frederick Beck.

13. Birthplace: Germany.

MOTHER

14. Maiden name: Unknown.

15. Birthplace

16. Informant: Mrs Margaret Gotthardt

Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 8 45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Feb. 8 (Date rec'd by registrar) 19 45 Victor R Beatty MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 6 19 45, at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/30/45 19..., to 2/6 19 45;

and that I last saw him alive on 1/30/45 19...

Immediate cause of death	DURATION
Gangrene Foot	
Lower Leg.	
Due to Arteriosclerosis.	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: John R Rozzell M D
M. D. or other

Address Cumberland Md Date signed 2/7/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01204

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs.
Hospital, Institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 617 South St.
(If rural, give LOCATION)
2.(a) If veteran, name war: —

3.(a) FULL NAME: Helen Catherine Berryman

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Melvin R. Berryman
6.(c) If alive, give age: ____ years

7. Birth date of deceased (mo., day, yr.): May 5 1899

8. AGE:	Years	Months	Days	If less than one day
	45	8	27	____ hrs. ____ min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: —

FATHER
12. Name: John Brehm
13. Birthplace: Pa.

MOTHER
14. Maiden name: Anna Cope
15. Birthplace: Md.

16. Informant: Mrs. Dorothy Wilt
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 5 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Burial Park
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb. 5 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 1st 1945, at 11:00 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1st 1945, to Feb 1st 1945 and that I last saw h[illegible] alive on Feb 1st 1945

Immediate cause of death	DURATION
Chronic Myocarditis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury: ____ Injured at work? ____

23. SIGNATURE: L. D. Meekins M.D. M. D. or other
Address: 49 Greene St. Date signed 2-2-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

CERTIFICATE OF DEATH

01205

Reg. Diat. No. .....

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2½ hours
Hospital, institution, or street address where death occurred:
Miners' Hospital
How long in hospital or institution? 2½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Pekin
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME: George L. Bittinger

3. (b) Social Security Number: —

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Margaret Kasnick
6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): April 5, 1878

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
66	10	18		

9. Birthplace: Farm — Garrett Co., Md
(Town, county, and state)
10. Usual occupation: Laborer
11. Industry or business: Koffa Mine
FATHER 12. Name: Levi J. Bittinger
13. Birthplace: Unknown
MOTHER 14. Maiden name: Rebecca A. Broadwater
15. Birthplace: Farm Garrett Co. Md
16. Informant: Mrs. Angus Donaldson
Address: Pekin, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 18 1945 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Macon, —
18. Funeral director: Wm. Eichhorn
Address: Lonaconing, Md
19. 2-17 1945 Mrs. Nancy M. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15, 1945 at 11 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 15 1945 to Feb. 15 1945 and that I last saw h. living alive on Feb 15 1945

Immediate cause of death	DURATION
Uremia	2½ hrs.
Due to: Chronic Nephritis;	
Duration: Indefinite; for some time	
Due to: Cause?	
Other conditions: Was brought into the hospital in a semicomatose condition.	

(Include pregnancy within 3 months of death)

Major findings of operations: —
Date of op. —
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE: M. E. Gatten M. D.
M. D. or other
Address: Frostburg, Md. Date signed: 2/17/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

CERTIFICATE OF DEATH

01206

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, Institution, or street address where death occurred: 226 Everett Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 226 Everett Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mrs Mary Agnes Boettner

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John H. Boettner

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Aug 10 1876

8. AGE: Years	Months	Days	If less than one day
68	6	2	...hrs. ...min.

9. Birthplace: Pearly, Iowa (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER — 12. Name: George Whitefield

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Catherine ?

MOTHER — 15. Birthplace: Ireland

16. Informant: John H. Boettner

Address: 226 Everett Ave - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 14 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer.

Address: Cumberland Md.

19. Feb. 14 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1945 at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945 to Feb 12 1945

and that I last saw her alive on Feb 11 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	1 day
Due to	
Due to	
Other conditions: Diabetes	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: C. A. Trevaskis, M.D. M. D. or other

Address: Cumberland, Md Date signed 2/14/45

-Trevaskis-

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01207

Reg. Dist. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 yrs
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 8 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 709 Washington St
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Ralph Childs Bowen

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Rose Callaghan
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): ? ? 1884

8. AGE: Years 60 | Months ? | Days ? | If less than one day: ____ hrs. ____ min.

9. Birthplace: Calvert Co. Md. (Town, county, and state)
10. Usual occupation: Physician
11. Industry or business

FATHER
12. Name: Reuben Bowen
13. Birthplace: Md.

MOTHER
14. Maiden name: Ellie Bowen
15. Birthplace: Md.

16. Informant: Capt. Francis Bowen.
Address: Livingston Conn.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2 45 (month) (day) (year)
Cemetery or crematory: St Peter & Pauls Cem
Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. Mar 1 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1945, at 12:30 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 1 1944, to Feb 28 1945
and that I last saw h.xx alive on Feb 28 1945

Immediate cause of death	DURATION
(a) Hypertension	10 yrs (?)
Due to: (b) Chr myocarditis	1 yr
Due to: (c)	
Due to: (d)	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ____ Date of op. ____
Autopsy results: ____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ____ Date of ____
Where did injury occur? ____ (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) ____
Means of injury ____ Injured at work?

23. SIGNATURE: Lyle R. Everhart M.D. M. D. or other
Address: 36 Arlene St Cumberland, Md. Date signed: 3/1-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

01208

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 11 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 517 South Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Mrs. Mary Bowers

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John Bowers
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): June 12 1869

8. AGE: Years	Months	Days	If less than one day
75	7	28	....hrs. ....min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: Henry Appel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Slider
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 14 45 (month) (day) (year)
Cemetery or crematory: Little Orleans Cem.
Location: " " End.
18. Funeral director: Louis Stein Sons.
Address: Cumberland
19. Feb. 15, 1945 (Date rec'd by registrar) Winter R. Mantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-10-45 at Home

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12-30-1944 to 2-10-1945 and that I last saw her alive on 2-10-1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op. None
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed 2-10-45

DR. GRACIE

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01269

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEG.

City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 27 DAYS

Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 27 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MD. County GARRETT

City or town FRIENDSVILLE
(If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME EMMA F. BOYD

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife ROBERT BOYD

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) AUG. 3, 1869

8. AGE: Years	Months	Days	If less than one day
75	5	1	..... hrs. ..... min.

9. Birthplace MD.
(Town, county, and state)

10. Usual occupation HWK.

11. Industry or business

FATHER 12. Name William MORGAN

13. Birthplace U. S. A.

MOTHER 14. Maiden name Christina Bender

15. Birthplace U. S. A.

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7, 1945 (month) (day) (year)

Cemetery or crematory Friendsville Cem

Location Friendsville, Md.

18. Funeral director W. H. Savage

Address Friendsville

19. Feb. 7, 1945 (Date rec'd by registrar) Wister R. Frantz, M.D. (Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 4 1945 at 9:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 8 1945, to Feb 4 1945

and that I last saw h alive on Feb 4 1945

Immediate cause of death	DURATION
Peritonitis	
Due to Ruptured Appendix	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations Gen thought had adenoma Ca? - Ruptured Appendix Date of op. Jan 9-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE W. G. Grace M. D. or other

Address Cumberland Date signed Feb 9 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-a)

CERTIFICATE OF DEATH

01210

Reg. Dist. No. 10

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: County:

City or town:
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Augustus Brailer

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary A Pendlebury

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 27. 1862

8. AGE: Years	Months	Days	If less than one day
82	5	16	hrs. min.

9. Birthplace: Mt Savage
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: R.R. Co

FATHER 12. Name: Augustus Brailer

13. Birthplace: Germany

MOTHER 14. Maiden name: Cecilia Logdon

15. Birthplace: Maryland

16. Informant: Joseph M Brailer

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 16 '45 (month) (day) (year)

Cemetery or crematory: St Patricks Cem

Location: Mt Savage Md.

18. Funeral director: Louis Stein Sons

Address: Cumberland Md

19. Feb. 14 1945 (Date rec'd by registrar) Vernon McDermitt Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 13 1945 at 9:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 1944 to Feb. 12 1945 and that I last saw him alive on February 12 1945

Immediate cause of death: Myocarditis — DURATION: 10 days

Due to: Arteriosclerosis. Chronic Nephritis.

Due to:

Other conditions: Gangrene Rt. foot.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: William E. Moseley M.D.
M. D. or other

Address: Mt Savage Md. Date signed: Feb. 14 - 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1445a)

CERTIFICATE OF DEATH

01211

Reg. Dist. No. 9

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg (If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md. County: Garrett

City or town: Rural near Grantsville, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Elmira L. Bullock

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Richard Bullock

6.(c) If alive, give age: 26 years

7. Birth date of deceased (mo., day, yr.): February 23, 1925

8. AGE:

Years	Months	Days	If less than one day
19	11	31	hrs. min.

9. Birthplace: Rural near Grantsville, Md. (Town, county, and state)

10. Usual occupation: Naval Work

11. Industry or business

FATHER — 12. Name: Christian Mersbach

FATHER — 13. Birthplace: Rural near Grantsville, Md.

MOTHER — 14. Maiden name: Minnie Spiker

MOTHER — 15. Birthplace: Rural near Grantsville, Md.

16. Informant: Christian Mersbach

Address: R. D. 1 Salisbury, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-25-1945 (month) (day) (year)

Cemetery or crematory: Mersbach

Location: Rural near Grantsville, Md.

19. Funeral director: Wm. Winterberg

Address: Grantsville Md

19. 2-22 1945 Mrs. Nancy V. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 1945 at 5:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 21 1943 to Feb 22 1945 and that I last saw her alive on Feb 22 1945

Immediate cause of death	DURATION
Convulsions	7
Due to Septicemic Toxemia	1
Due to Complications of Pregnancy	7
	1
Other conditions: 7 months Pregnant	

(Include pregnancy within 3 months of death)

Major findings of operation: None Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: W. D. McLane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed 2-22-45

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186)

01212

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 yrs.

Hospital, institution, or street address where death occurred: Baltimore Pike, Rt. #2

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Near Cumberland Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. R.F.D. 2 Cumberland, Md.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Mrs Nancy Alberta Chaney

3. (b) Social Security Number None

4. Sex	5. Color or race	8.(a) Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife Leroy Chaney

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 4, 1855

8. AGE:

Years	Months	Days	If less than one day
89	2	18	..... hrs. ..... min.

9. Birthplace Cumberland Allegany Co. Md

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER

12. Name Robert Christie

13. Birthplace Allegany Co. Md.

MOTHER

14. Maiden name Mary Jane Selby

15. Birthplace Allegany Co. Md

16. Informant Mrs John H. Yontz

Address R.F.D. 2 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 24, 1945 (month) (day) (year)

Cemetery or crematory Pleasant Grove Cemetery

Location Baltimore Pike near Cumberland

18. Funeral director John J. Hafer

Address Cumberland Md.

19. Feb. 24 1945 (Date rec'd by registrar) Hunter R. Dent, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 22, 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 27, 1945 to Feb 22, 1945

and that I last saw h.. alive on Feb. 22, 1945

Immediate cause of death	Hypostatic Pneumonia	DURATION
Due to	Fract. Neck of R. Femur	4 wks.
Due to		
Other conditions		

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Injury of Feb 6, 1945

Where did injury occur? Cumberland Allegany Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) At home

Means of injury Slipped on ice. Injured at work? No

23. SIGNATURE C.W. Snyder M. D. or other

Address Cumberland Md. Date signed 2-23-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

CERTIFICATE OF DEATH

01213

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, Institution, or street address where death occurred:

S/T Memorial Ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants gives residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 817 Memorial Ave

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME William J. Coleman

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 1865 ?

8. AGE: Years 79 | Months | Days | If less than one day ..... hrs. ..... min.

9. Birthplace Baltimore Md (Town, county, and state)

10. Usual occupation Farmer (Retired)

11. Industry or business

FATHER 12. Name John Coleman

13. Birthplace Ireland

MOTHER 14. Maiden name Mary Lawler

15. Birthplace Ireland.

16. Informant Jos A Coleman

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 13 45 (month) (day) (year)

Cemetery or crematory St Patricks Cem.

Location Cumberland, Md

18. Funeral director Louis Stein Inc

Address Cumberland, Md

19. Feb. 12, 1945 (Date rec'd by registrar) Walter R. Canty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb. 10, 1945 at 10 45 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 1, 1944 to Feb. 10, 1945 and that I last saw him alive on Feb 5, 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	5 yrs
Due to Uraemia	3 wks.
Due to	
Other conditions	

(Includes pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Clark K. Lucas M. D. or other

Address Cumberland, Md Date signed Feb. 12, 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. G 9 4 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (730)

CERTIFICATE OF DEATH

01214

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 15 yrs

Hospital, institution, or street address where death occurred: 39 Oak St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Oak St. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Golden W. Corrick

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mattie Rose

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 1 - 1875

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
69 67	10	3		

8. Birthplace: Parsons W. Va. (Town, county, and state)

10. Usual occupation: Engineer (Retired)

11. Industry or business: B & O Ry.

FATHER — 12. Name: Baxter Corrick

FATHER — 13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Anne Hayes

MOTHER — 15. Birthplace: W. Va.

16. Informant: Mrs. Mattie Corrick

Address: Cumberland

17. Burial, cremation, or removal. Which?: Burial & removal Date thereof: Feb 7 45 (month) (day) (year)

Cemetery or crematory: Jamison Cem.

Location: Jamison, W. Va.

18. Funeral director: Louis Stein Inc.

Address: Cumberland.

19. Feb. 6 1945 (Date rec'd by registrar) Nate A. Dantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 4 1945, at 7:20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1943, to Feb. 4. 1945

and that I last saw him alive on Feb. 3. 1945

	DURATION
Immediate cause of death: Cerebral Hemorrhage	2 days
Due to: Myocarditis (Rheumatic)	8 yrs.
Due to: Nephritis	2 weeks
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Clark E. Jones M.D. or other

Address: Cumberland Date signed: 2/5/45.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01215

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 20 yrs
Hospital, Institution, or street address where death occurred:
653 Baker St.
How long in hospital or Institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 653 Baker St.
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME David A Crawford.

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Mary Albright
6.(c) If alive, give age 63 years

7. Birth date of deceased (mo., day, yr.) Oct 6 1871

8. AGE: Years	Months	Days	If less than one day
73	3	28	...hrs. ...min.

9. Birthplace Keyser W. Va.
(Town, county, and state)
10. Usual occupation Sheet metal worker
11. Industry or business Retired
FATHER 12. Name David K. Crawford.
13. Birthplace W. Va.
MOTHER 14. Maiden name Nettie Hershman
15. Birthplace Md.
16. Informant Mrs Melvin Brant
Address Cumberland Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 6 45 (month) (day) (year)
Cemetery or crematory Allegany Cem.
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19. Feb 6 1945 (Date rec'd by registrar) Hunter A Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 3 1945 at 6 05 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 29 1945 to Feb 3 1945 and that I last saw h. alive on Feb 3 1945

	DURATION
Immediate cause of death Septicaemia	
Due to a carbuncle on neck	3 wks
Due to	
Other conditions Diabetes	some yrs

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...
Autopsy results ...
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ... Date of ...
Where did injury occur? ... (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?) ...
Means of injury ... Injured at work?

23. SIGNATURE S. V. Deming M.D.
M. D. or other
Address 125 Bedford St Date signed 2-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01216

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 7 Hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Mary Ann Crane

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Frederick D. Crane

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): May 22 - 1869

8. AGE: Years: 75 Months: 4 Days: 3 If less than one day: ..... hrs. ..... min.

9. Birthplace: Eckhart, Allegany, Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Marshall Peoples

FATHER — 13. Birthplace: England

MOTHER — 14. Maiden name: Mary E. Wallbanks

MOTHER — 15. Birthplace: Scotland

16. Informant: Fred Crane

Address: 135 S. Water St. Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-27-1945 (month) (day) (year)

Cemetery or crematory: Eckhart Cemetery

Location: Eckhart, Md.

18. Funeral director: Daniel Kaiser

Address: Frostburg, Md.

19. 2-26-45 (Date rec'd by registrar) Mrs. Harvey H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1945 at 4 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 6 1945 to Feb. 25 1945 and that I last saw h.. alive on Feb. 24 1945

Immediate cause of death	DURATION
Chronic myocarditis	2 yrs.
Due to: Arteriosclerosis	
Other conditions: Chronic Cholecystitis.	

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl M. D. or other

Address: Frostburg, Md. Date signed 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9th a

01217

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: 301 Baltimore Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Pa. County: Fayette
City or town: Ohio Pyle
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Mrs Lucindia Davis

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	

6.(b) Name of husband or wife: Edward Davis
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 9, 1881

8. AGE: Years: 63 | Months: 4 | Days: 4 | If less than one day: hrs. min.

9. Birthplace: Ohio Pyle - Fayette Co., Pa.
(Town, county, and state)

10. Usual occupation: Housework
11. Industry or business: at Home

FATHER
12. Name: John Shipley
13. Birthplace: Ohio Pyle, Pa

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs Effie Orndorff
Address: 301 Baltimore - Cumb Rt.

17. Burial
(Burial, cremation, or removal, Which?)
Date thereof: Feb 18, 1945
(month) (day) (year)
Cemetery or crematory: Cedar Hill Cemetery
Location: Washington D. C.

18. Funeral director: John J Haley
Address: Cumberland Md

19. Feb. 14, 1945
(Date rec'd by registrar)
Wintie L. Brantz, M.D.
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 13, 1945, at 11 15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 12, 1945, to Feb 13, 1945
and that I last saw her alive on Feb 12, 1945

Immediate cause of death	DURATION
Coronary occlusion	1 week
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: R. F. Trevaskis, M.D.
M. D. or other
Address: Cumberland Md Date signed: 2/14/45

Trevaskis

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (32)

CERTIFICATE OF DEATH

01218 4
Reg. Diat. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 65 Years

Hospital, institution, or street address where death occurred:
RFD # 1, Cumberland

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No. RFD # 1, Cumberland
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Clarence K. Defibaugh

3.(b) Social Security Number

214-07-1922

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: Jessie Defibaugh

6.(c) If alive, give age: 64 years

7. Birth date of deceased (mo., day, yr.): January 26 1876

8. AGE: Years	Months	Days	If less than one day
69	0	14	...hrs. ...min.

9. Birthplace: State Line, Bedford Co., Penna.
(Town, county, and state)

10. Dsual occopation: Machenist

11. Industry or business: Celense Corp

FATHER
12. Name: Frances S Defibaugh
13. Birthplace: Bedford, Pa.

MOTHER
14. Maiden name: Katherine Earnest
15. Birthplace: Dutch Corner, Pa.

16. Informant: Mrs. Clarence K. Defibaugh
Address: RFD # 1, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/13/45 (month) (day) (year)

Cemetery or crematory: Hill Crest Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb. 17 1945 (Date rec'd by registrar) Walter R. Trauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 10 1945, at 6 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 15 1944 to Feb 10 1945 and that I last saw him alive on Feb 9 1945

	DURATION
Immediate cause of death: Coronary Thrombosis	4 hrs.
Due to: Cardiac Vascular Disease	10 yrs.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. D. or other

Address: 133 Va Ave Date signed 2-12-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01219

4

Reg.-Dist. No.

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: 13 Decatur St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural

(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Josiah green Dolly

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clersa Dolly.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 25, 1868

8. AGE: Years	Months	Days	If less than one day
77	0	3	hrs. min.

9. Birthplace: Pendleton County, W. Va.

(Town, county, and state)

10. Usual occupation: Retired Farmer

11. Industry or business: General Farming

FATHER 12. Name: G. Washington Dolly

13. Birthplace: Virginia

MOTHER 14. Maiden name: Charlotte Jane Kinamon

15. Birthplace: Virginia

16. Informant: Russell Dolly

Address: Flintstone, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2, 1945 (month) (day) (year)

Cemetery or crematory: Brethren Cemetery

Location: Flintstone, Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Mar 1, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 28, 1945, at 4:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 13 1944 to February 28 1945

and that I last saw h... alive on February 20 1945

Immediate cause of death	DURATION
Congestive heart failure	one year
Due to: Chronic myocarditis	several years
Due to:	
Other conditions: arteriosclerosis	several years

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: L. Wingo M.D. M. D. or other

Address: Long Mdw. Date signed: 3-1-45

F. Wingo

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33)

CERTIFICATE OF DEATH

01220

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?:

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 2 mths

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. Pa. County: Somerset

City or town: Wellersburg

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME George Ellis Dom (Dom)

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Infant

6.(b) Name of husband or wife:

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Oct. 25th - 1944

8. AGE:

Years	Months	Days	If less than one day
	3	22	..... hrs. ..... min.

9. Birthplace: Frostburg, Allegany, Md.

(Town, county, and state)

10. Usual occupation:

11. Industry or business

FATHER — 12. Name: George E. Dom (Dom)

13. Birthplace: Wellersburg, Pa.

MOTHER — 14. Maiden name: Mary Jane Smith

15. Birthplace: Bedford Sheet, Md

16. Informant: George E. Dom

Address: Wellersburg, Pa.

17. Burial, cremation, or removal. Which? Burial — Date thereof: 2-18-1945 (month) (day) (year)

Cemetery or crematory: Lutheran Cemetery

Location: Wellersburg, Pa.

18. Funeral director: Jacob Diehl

Address: Frostburg, Md.

19. 2-17 1945 — Mc. Nancy H. Rae, Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17 1945 at 8:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-29 1945, to 2-17 1945; and that I last saw him alive on 2-16 1945.

	DURATION
Immediate cause of death: Influenzal meningitis	20 days.
Due to: Typhoid B.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: H. C. Diehl M.D.

M. D. or other

Address: Frostburg, Md. Date signed: 2/17/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

CERTIFICATE OF DEATH

01221

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland (RURAL)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred:
Celanese Co. Of America
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Alleg.
City or town: R.F.D. 1 Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: LaVale Blvd
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Reuben Clyde Douty

3.(b) Social Security Number: 214 - 05 - 6444

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Carrie Harold
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 16 1887

8. AGE: Years	Months	Days	If less than one day
57	6	10	hrs. min.

9. Birthplace: Union City Wr. Buffalo Twp. Pa.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Celanese Co.
FATHER 12. Name: Frank S. Douty
13. Birthplace: Clinton Tw. Pa.
MOTHER 14. Maiden name: Sarah Elizabeth Rose
15. Birthplace: Union Pa.
16. Informant: Mrs Carrie Douty
Address: LaVale, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 1 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem
Location: Cumberland, Md.
18. Funeral director: Louis Stein Inc.
Address: 117 Frederick St.
19. Mar. 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION A.

20. DATE OF DEATH: February 26th, 1945, at 10.55 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ... 19... to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide... Date of ...
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Clarence H. Brown M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 2-26-45.

Deputy Medical Examiner for Allegany Co.

Dr. Eliason

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01222

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: La Vale
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME
Billy Eaton

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 13, 1944

8. AGE: Years	Months	Days	If less than one day
3	3		..... hrs. ..... min.

9. Birthplace: Cumberland, Maryland
(Town, county, and state)
10. Usual occupation: Infant
11. Industry or business
FATHER 12. Name: Earl Eaton
FATHER 13. Birthplace: Maryland
MOTHER 14. Maiden name: Mary Trozzo
MOTHER 15. Birthplace: Maryland
16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/24/45 (month) (day) (year)
Cemetery or crematory: St Peter & Paul Cemetery
Location: Cumberland, Md.
18. Funeral director: William H. Kight
Address: Cumberland, Md.
19. Feb 24 1945 (Date rec'd by registrar) Hunter R Frantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23 1945, at 2:50 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 22 1945, to Feb 23 1945
and that I last saw h.. alive on Feb 22 1945

Immediate cause of death	DURATION
Virus Pneumonia	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Eliason M.D.
Address: 126 Glenn St Cumberland Md. M. D. or other
Date signed 2/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160)

01223

CERTIFICATE OF DEATH

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 10 minutes
Hospital, institution, or street address where death occurred:
Miners Hospital
How long in hospital or institution? 10 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5 Centennial
(If rural, give LOCATION)
2.(a) If veteran, name war —

3. (a) FULL NAME Baby Boy Elrick

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife —

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) February 4, 1945

8. AGE: Years — | Months — | Days — | If less than one day — hrs. 10 min.

8. Birthplace Frostburg Md (Town, county, and state)

10. Usual occupation None

11. Industry or business —

FATHER
12. Name Charles Edward Elrick
13. Birthplace Frostburg Md

MOTHER
14. Maiden name Sylvia LaDaine Elrick
15. Birthplace Dawson Pennsylvania

16. Informant Charles Edward Elrick
Address 5 Centennial St Frostburg

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 5 1945 (month) (day) (year)
Cemetery or crematory Allegany Cemetery
Location Frostburg Md.

18. Funeral director J. J. Dierst
Address Frostburg Md.

19. 2-5 1945 Miss Nancy N. Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 4 1945, at 9:25 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/4 1945 to 2/4 1945 and that I last saw h. alive on 2/4 1945

	DURATION
Immediate cause of death Prematurity	
Due to Precipitate labor	
Due to Pre eclamptic toxemia of mother	
Due to —	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations —
Date of op. —
Autopsy results —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Hilda Swelbar MD M. D. or other
Address Frostburg Md Date signed 2/4/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

01224

Reg. Dist. No. 4

VS A15 PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred: 646 N. Mechanic St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No. —
(If rural, give LOCATION)
2.(a) If veteran, name war —

3.(a) FULL NAME John Alex Emerick
3.(b) Social Security Number None

4. Sex Male
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Clara J Kimmell
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) Sept 7 1857
8. AGE: Years 87 Months 5 Days 26 If less than one day ... hrs. ... min.
9. Birthplace Pa.
(Town, county, and state)
10. Usual occupation Farmer (Retired)
11. Industry or business
FATHER 12. Name Josiah Emerick
13. Birthplace Pa.
MOTHER 14. Maiden name Indiana Davis
15. Birthplace Pa.
16. Informant Mrs J J Moore
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 3 45 (month) (day) (year)
Cemetery or crematory Rose Hill Cem.
Location Cumberland
18. Funeral director Louis Stein
Address Cumberland
19. Mar. 3 1945 (Date rec'd by registrar) Walter R Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 28 1945, at 6 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 28 1945
and that I last saw h— alive on Feb 27 1945

	DURATION
Immediate cause of death [illegible]	
Hypostatic Congestion lungs	3 days
Due to Fracture R Hip about 5th Feb	
Due to Accidental fall [illegible]	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Accident Date of February 5th 1945
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) On street, in front of house
Means of injury Accidental fall Injured at work?

23. SIGNATURE [illegible] M. D. or other
Address Cumberland Date signed March 1/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

(94a)

01225

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 34 yrs

Hospital, Institution or street address where death occurred

707 Long Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newboro infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 707 Long Ave

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Helen I. Erickson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Roland Erickson

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 15 1910

8. AGE:

Years	Months	Days	If less than one day
34	1	27	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name William R. Easton

13. Birthplace Md.

MOTHER 14. Maiden name —

15. Birthplace —

16. Informant Roland Erickson

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-45 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland

18. Funeral director Louis Stein Inc.

Address Cumberland

19. Feb. 14 1945 Walter R. Beauty M.D. Registrar

(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH February 11th., 1945, at about 9:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death Coronary Occlusion — DURATION

Due to .....

Due to .....

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations ---

Date of op. .....

Autopsy results no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Bruce H. Larson, M.D. M. D. or other

Address Cumberland, Maryland Date signed 2-12-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Durrett

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 48-E

CERTIFICATE OF DEATH

01226

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 years

Hospital, institution, or street address where death occurred:
Memorial Hospital

How long in hospital or institution? 261 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 310 Grand Avenue
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs. Ida M. Eury

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Divorced

6.(b) Name of husband or wife: William Busy

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 15 1891

8. AGE: Years	Months	Days	If less than one day
53	9	8	..... hrs. ..... min.

9. Birthplace: Pennsylvania
(Town, county, and state)

10. Usual occupation: None

11. Industry or business

FATHER
12. Name: Columbus W. Eury
13. Birthplace: Maryland

MOTHER
14. Maiden name: Anna Fauble
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/27/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb 27 1945 (Date rec'd by registrar) Walter R. Frantz, M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 23, 1945 at ..... M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from June 1944 to Feb. 23, 1945

and that I last saw her alive on Feb. 23, 1945

Immediate cause of death	DURATION
Cerebrovascular Accident	18 mos.
Due to Hypertension	3 yrs.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

D. SIGNATURE Clay R. Turner M. D. or other

Address Cumberland Date signed 2/24/45

MAROON RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23rd)

CERTIFICATE OF DEATH

M Lane

01227

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Eckhart

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(n) If veteran, name war

3. (a) FULL NAME Lucindo Fabbri

3. (b) Social Security Number none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife Benilda Fabbri

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.) April 29, 1885

8. AGE:

Years	Months	Days	If less than one day
59	9	22	hrs. min.

9. Birthplace Italy
(Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal mines

FATHER

12. Name Joseph Fabbri

13. Birthplace Italy

MOTHER

14. Maiden name Unknown

15. Birthplace

16. Informant Oliver Fabbri

Address Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 23 1945 (month) (day) (year)

Cemetery or crematory St Michaels Cemetery

Location Frostburg Md

18. Funeral director J. J. Durst

Address Frostburg Md.

19. 2-22 1945 Mrs. Nancy N. Roe
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 21 1945, at 1:00 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 13 1943 to Feb 21 1945 and that I last saw him alive on Feb 20 1945

	DURATION
Immediate cause of death Cerebral Embolism	1 Day
Due to Chr. Myocarditis	several years
Due to Silicosis	many years
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W O M Lane Jr M.D. M. D. or other

Address Frostburg Md Date signed Feb 22 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (186-a)

CERTIFICATE OF DEATH

01228

Reg. Dist. No. 7

1. PLACE OF DEATH:

County: Allegany

City or town: Mexcastle Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mexcastle
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: Amanda Warnick Daingiewe

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: James Daingiewe

6.(c) If alive, give age: 87 years

7. Birth date of deceased (mo., day, yr.): Sept. 15, 1854

8. AGE:

Years	Months	Days	If less than one day
90	4	21	hrs. min.

9. Birthplace: Easton, Alleg. Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER
12. Name: James Warnick
13. Birthplace: Garrett Co. Md.

MOTHER
14. Maiden name: Sarah Poland
15. Birthplace: Garrett Co. Md.

16. Informant: Mrs. Samuel Mc Cutcheon

Address: Mikep, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Feb. 10 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill

Location: Moscow Md.

18. Funeral director: Mrs Jay Boal Berry

Address: Westernport, Md.

19. Feb 7 1945 (Date rec'd by registrar) L. A. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 6, 1945, at 7:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1 1945 to Feb. 6 1945 and that I last saw h[illegible] alive on Feb 5 th 1945

Immediate cause of death: Senility & shock due to fracture femur

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: Feb. 1st 45

Where did injury occur? In town (City or town) Allegany (County) Md (State)

Injured at home, farm, industry, public place (where?): Home

Means of injury: Fall in room Injured at work? No

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other

Address: Lonaconing, Md. Date signed: Feb. 7 '45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS. A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97

CERTIFICATE OF DEATH

01229

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 41 yrs

Hospital, institution, or street address where death occurred: Sylvan Retreat

How long in hospital or institution? 41 yrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Valley Road

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Jeramiah Felton

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Catherine Felton

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): 1863 4

8. AGE: Years: 80 | Months: | Days: | If less than one day: ..... hrs. ..... min.

9. Birthplace: England (Town, county, and state)

10. Usual occupation: Inm Institution for Insane

11. Industry or business:

FATHER — 12. Name: Unknown

FATHER — 13. Birthplace: "

MOTHER — 14. Maiden name: "

MOTHER — 15. Birthplace: "

16. Informant: Supt of Sylvan Retreat

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 6, 1945 (month) (day) (year)

Cemetery or crematory: Allegany County Cemetery

Location: Cumberland Md.

18. Funeral director: John J Hafer

Address: Cumberland Md

19. Feb. 6 1945 (Date rec'd by registrar) Winter R. Hartz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2-3-1945, at 5:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1-1-1945 to 2-3-1945 and that I last saw h[illegible] alive on 1-31-1945

Immediate cause of death	DURATION
Arteriosclerosis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None Date of op.: None

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other

Address: Cumberland Date signed: 2-5-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94-20)

CERTIFICATE OF DEATH

01230

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2½ weeks

Hospital, Institution, or street address where death occurred:
Miner's Hospital

How long in hospital or institution? 2½ weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Garrett

City or town: Avilton - Rural
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Otho Speelman Fike

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Linnie Weitzell Fike

6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): August 13, 1877

8. AGE: Years	Months	Days	If less than one day
67	6	-	...hrs. ...min.

9. Birthplace: Asher Glade, Garrett, Maryland
(Town, county, and state)

10. Usual occupation: Farming

11. Industry or business: Farming

FATHER
12. Name: Ami M. Fike
13. Birthplace: Unknown

MOTHER
14. Maiden name: Caralyn Catherine Barnhouse
15. Birthplace: Unknown

16. Informant: Mildred L. Fike

Address: Lonaconing, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-14-1940 (month) (day) (year)

Cemetery or crematory: Weitzell Cemetary RFD 1, Box 24

Location: Avilton, Maryland Lonaconing, Md.

18. Funeral director: Allen Wineberg

Address: Grantsville Md

19. Feb 12 1945 Mrs Nancy H. Rice
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12 1945, at 4 25/60 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 26 1945, to February 12 1945 and that I last saw h. living on February 11 1945

Immediate cause of death	DURATION
Pulmonary infarct	24 hrs
Due to: Coronary Thrombosis	2½ wks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: Hilda Jane Lichtfoy M.D.
M. D. or other

Address: Frostburg Date signed 2/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01231

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If ontside city or town limits, write RURAL and give nearest town)

How long in above place of death? 80 Years

Hospital, institution, or street address where death occurred:

436, Goethe St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 436, Goethe St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Christania Dorthea Fillinger

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: Martin Fillinger

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 28, 1857

8. AGE: Years	Months	Days	If less than one day
87	5	19	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany Co, Maryland

(Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER

12. Name: Unknown

13. Birthplace: Germany

MOTHER

14. Maiden name: Unknown

15. Birthplace: Germany

16. Informant: Joseph Zapf

Address: 436, Goethe St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/10/45 (month) (day) (year)

Cemetery or crematory: St Lukes Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb 9 1945 (Date rec'd by registrar) Winter R. Trautz, M Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 7" 1945 at 12 noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 1945, to Feb 7 1945 and that I last saw her alive on Jan 29 1944

Immediate cause of death	DURATION
Chronic Nephritis	2 yrs
Due to	
Due to	
Other conditions Arteriosclerosis	5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: R. A. Trevaskis M.D.

Address: Cumberland, Md. M. D. or other Date signed: Feb 7-'45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (4)

01232

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 17 yrs.

Hospital, institution, or street address where death occurred: 705 Frederick St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 705 Frederick St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Martha Langford Fletchinger

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Vincent Fletchinger

6.(c) If alive, give age 53 years

7. Birth date of deceased (mo., day, yr.) Sept 6, 1884

8. AGE: Years	Months	Days	If less than one day
60	4	27	...hrs. ...min.

9. Birthplace Borden Mines, Allegany Co., Md (Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home.

FATHER 12. Name Thomas B. Evans

13. Birthplace Wales

MOTHER 14. Maiden name Mary Ann Langford

15. Birthplace Wales

16. Informant Vincent Fletchinger

Address 705 Frederick St. Cumb. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 8 1945 (month) (day) (year)

Cemetery or crematory Rolland Cemetery

Location Cumberland Md

18. Funeral director John J. Tales

Address Cumberland Md.

19. Feb. 8 1945 (Date rec'd by registrar) Vinton R. Trout, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 3 1945, at 8.45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 19, 1945, to Feb. 3 1945

and that I last saw h... alive on ... 19...

Immediate cause of death	DURATION
Chronic Nephritis	2 yrs.
Due to	
Due to	
Other conditions Diabetes Mellitus	7 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations ... Date of op. ...

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE Charlotte B. Gardner M. D. or other

Address Cumberland Md Date signed 2/7/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

1945 - 2 - 4
1944 - 13 - 34
1875 - 12 - 11
69 - 1-23

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133-a)

01233

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12. Years

Hospital, Institution, or street address where death occurred:

118. Valley St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 118. Valley St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME

Mamie Virginia Foreman

3.(b) Social Security Number

None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Eugene J Foreman

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): June 17, 1905

8. AGE: Years	Months	Days	If less than one day
39	7	19	...hrs. ...min.

9. Birthplace: Rock Enon, Virginia (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER

12. Name: Flavius L. Good

13. Birthplace: Rock Enon, Va.

MOTHER

14. Maiden name: Laura Shanholtz

15. Birthplace: Rock Enon, Va.

16. Informant: Eugene J. Foreman

Address: 118. Valley St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/8/45 (month) (day) (year)

Cemetery or crematory: Mt. Hebron Cemetery

Location: Winchester, Virginia

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb 7 1945 (Date rec'd by registrar) Walter R. Prantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 6 1945, at 4:40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 1944 to Feb 6 1945 and that I last saw h... alive on Feb 6 1945

	DURATION
Immediate cause of death: Acute Nephritis	6 weeks
Due to: Pneumonia	6 mos
Due to: Cystitis	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: T. Allen Glenn M. D. or other

Address: Cumberland Md. Date signed: Feb 6

4-5

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94(a)

CERTIFICATE OF DEATH

01234 6
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County Allegany
City or town Mc Coole (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 mo.
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DEACEASED:
(For newborn infants give residence of mother)
State Md. County Garrett
City or town Swanton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Harriet Friend

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife John W. Friend
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.) Mar 21, 1855

8. AGE: Years	Months	Days	If less than one day
89	11	1	..... hrs. ..... min.

9. Birthplace Swanton - Garrett - Md. (Town, county, and state)
10. Usual occupation Houses - wife.
11. Industry or business Own home
FATHER 12. Name Levi Coon
13. Birthplace Mt. Savage, Md.
MOTHER 14. Maiden name not known
15. Birthplace
16. Informant Gilbert Friend
Address Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 25 1945 (month) (day) (year)
Cemetery or crematory U. B. cemetery
Location Swanton, Md
18. Funeral director Ellsworth & Byrd
Address Westernport, Md
19. Feb. 25 1945 (Date rec'd by registrar) A. Baynesaker M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 22 19 45 at 7.30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

	DURATION
Immediate cause of death Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Pierce H. Borson, M.D. M. D. or other
Address Cumberland, Maryland Date signed 2-25-45
Deputy Medical Examiner - Allegany Co.

(M)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (937)

01235

CERTIFICATE OF DEATH

Reg. Diat. No. 14

1. PLACE OF DEATH:
County Allegany
City or town Cellerslee
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Life
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cellerslee
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Mary Curtz Fuller

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife Charles Luther Fuller
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) September 1, 1861

8. AGE: Years 83 | Months 5 | Days 7 | If less than one day ..... hrs. ..... min.

9. Birthplace Wardensville, Virginia
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
12. Name Christine Curtz
13. Birthplace Germany

MOTHER
14. Maiden name No record.
15. Birthplace

16. Informant Mrs. Lee Faulkner
Address Cellerslie, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof February 12 1945 (month) (day) (year)
Cemetery or crematory ~~St. Peter & Paul~~ Hillcrest
Location Cumberland, Md.

18. Funeral director Harvey H. Feagler
Address Hyndman Pa

19. Feb 10 1945 (Date rec'd by registrar) Jr. Lloyd Wolfe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 8 1945 at 3P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1940, to February 1945
and that I last saw her alive on February 7 1945

Immediate cause of death	DURATION
Coronary Occlusion	15 yrs.
Due to Palsy	
Due to Chronic Hypertension	
Other conditions Arteriosclerotic Heart Disease.	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A Topper MD M. D. or other
Address Hyndman Pa Date signed 2-10-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

01236

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 69 yrs

Hospital, institution, or street address where death occurred: Braddock Road

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. Braddock Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Emma W Gilpin

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Edward Gilpin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): March 18, 1875

8. AGE: Years 69 | Months 10 | Days 21 | If less than one day: ..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: R. Nurse

11. Industry or business

FATHER 12. Name: Christopher Raider

FATHER 13. Birthplace: Germany

MOTHER 14. Maiden name: Catherine Schultz

MOTHER 15. Birthplace: Germany

16. Informant: Robert R. Gilpin

Address: Tyrone Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 11 45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. 2/11/45 (Date rec'd by registrar) 19 Walter R. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 9 1945 at 7a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1/5/45 19 to 2/9/45 19

and that I last saw h.. alive on 2/9/45 19

Immediate cause of death	DURATION
Coronary Thrombosis	Unk
Due to	
Arteriosclerosis	Unk
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: None Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: J. H. Matthews M. D. or other

Address: 60 S. Centre St. Date signed 2/10/45

DR. WILSON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-a)

CERTIFICATE OF DEATH

Mrs. H1237

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 327 Penna. Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Lyda Ellen Haney

3. (b) Social Security Number: 220-10-8696

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	White	Widowed

6.(b) Name of husband or wife: Orris G. Haney
6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): June 25 1878

8. AGE: Years 66 | Months 7 | Days 22 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Preston Co. W. Va. (Town, county, and state)
10. Usual occupation: Laundry worker
11. Industry or business: Memorial Hospital
FATHER 12. Name: Marellus Messenger
13. Birthplace: W. Va.
MOTHER 14. Maiden name: Anna B. Jeffries
15. Birthplace: W. Va.
16. Informant: Sussie B. Norris
Address: Cumberland, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 20 1945 (month) (day) (year)
Cemetery or crematory: Terra Alta Cem.
Location: Terra Alta, W. Va.
18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.
19. Feb. 19 1945 (Date rec'd by registrar) Walter R. Straub, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 17 1945, at 3:40 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-14- 1945 to Feb 17 1945 and that I last saw h[illegible] alive on Feb 17 1945

	DURATION
Immediate cause of death: Lobar pneumonia	24 hrs
Due to: Pulmonary embolism following fracture of	
Due to: Intestinal obstruction	24 hrs
Other conditions: strangulated femoral hernia	

(Include pregnancy within 3 months of death)

Major findings of operations: strangulated hernia Thrombosis mesenteric vessels Date of op. 2-16-45
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. M. Wilson M.D. M. D. or other
Address: Cumberland Md. Date signed 2-18-45

(M) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

(M)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

CERTIFICATE OF DEATH

01238

Reg. Dist. No. 4

Dr. Nelson

1. PLACE OF DEATH

County ALLEGANY

City or town CUMBERLAND, MD.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 7 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State PENNA. County SOMERST

City or town GLENCOE

(If outside city or town limits, write RURAL and give nearest town)

Street No. R. D

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME MRS. IDA HARTMAN

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	WIDOWED

6.(b) Name of husband or wife CHARLES HARTMAN

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JAN. 1, 1892

8. AGE: Years	Months	Days	If less than one day
53	1	14	..... hrs. ..... min.

9. Birthplace PENN R.D., Somerset County, Penna. (Town, county, and state)

10. Usual occupation HOUSE WIFE

11. Industry or business

FATHER 12. Name SAMUEL POORBAUGH

13. Birthplace PENNA.

MOTHER 14. Maiden name ALICE [redacted] Bauman

15. Birthplace PENNA.

16. Informant MRS. KRAUSE

Address BERLIN, PA.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 18, 1945 (month) (day) (year)

Cemetery or crematory Mt. Lebanon Cem

Location Glencoe, Penna, R.D.

18. Funeral director Johnson's Funeral Home

Address Berlin, Penna.

19. Feb. 17 1945 Winter L. Prantz M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 15, 1945 10;30 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 1-14- 19 45 to 2-15- 19 45

and that I last saw h.er alive on 2-16-45 19

Immediate cause of death	DURATION
Chronic nephritis	7
Due to	
Due to	
Other condition Secondary anemia	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. None

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Howard L. Nelson M.D. M. D. or other

Address Cumberland, Md Date signed 2-16-45

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47(2)

CERTIFICATE OF DEATH

01239

Reg. Dist. No. 4

M

D. Patterbone

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 Month

Hospital, Institution, or street address where death occurred:

Harold St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 439 Pennsylvania Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Mrs Catherine Rose Hawkins

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife Harold Hawkins

6.(c) If alive, give age 32 years

7. Birth date of deceased (mo., day, yr.) March 31, 1910

8. AGE:

Years	Months	Days	If less than one day
34	10	25	hrs. min.

9. Birthplace Butler Butler Co. Pa.

(Town, county, and state)

10. Usual occupation Housework

11. Industry or business At Home

FATHER

12. Name Roy Coast

13. Birthplace Pa.

MOTHER

14. Maiden name Betty Delihaugh

15. Birthplace Cumberland, Md.

16. Informant Harold Hawkins

Address 439 Pa Ave - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 1, 1945 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md

18. Funeral director John D. Hafer

Address Cumberland, Md.

19. Feb. 28, 1945 (Date rec'd by registrar) Walter R. Beatty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 26, 1945 at 6:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec. 29, 1944 to Feb 26, 1945

and that I last saw h... alive on Feb 25, 1945

Immediate cause of death	DURATION
Bronchogenic Carcinoma	8 mo
Right lung.	
Due to	
Due to	
Other conditions Metastasis to Mediastinum and liver	3 mo

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE R. Rhett Patterbone M. D. or ether

Address Memorial Hospital Date signed 2-28-45

DR. ELIASON

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18)

01240

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 43 yrs
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 15 PENNA. AVE.,
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME WILLIAM H. HINER

3.(b) Social Security Number 705-09-9454

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife ESTELLA, MESSICK
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) OCTOBER 11 1901

8. AGE:	Years	Months	Days	If less than one day
	43	4	3	..... hrs. ..... min.

9. Birthplace Cumberland Md (Town, county, and state)
10. Usual occupation Foreman
11. Industry or business Ry. Shops.
FATHER 12. Name WILLIAM H. HINER
13. Birthplace ~~MD.~~ Pa.
MOTHER 14. Maiden name SOMIE KNIPPLE
15. Birthplace ~~MD~~ Pa.
16. Informant Mrs Wm Hiner
Address Cumberland Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Feb 17 45 (month) (day) (year)
Cemetery or crematory Mt Herman Cem.
Location Rural Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland.
19. Feb 17 19 45 Walter R. Frantz M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 14, 19 45 at 3:30 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 10 19 45 to Feb. 14 19 45 and that I last saw h... alive on Feb 14 19 45

Immediate cause of death Acute Nephritis. DURATION 7 days
Underlying cause: Unknown
Due to No Contributing factors found. Duration two weeks
Due to
Other conditions Possible streptococcus infections
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE H. H. Grayson M.D.
Address 36 Fort St Cumberland Md M. D. or other
Date signed 2/16/45

MARGIN RESERVED FOR BINDING (1)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-0

01241

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County Allegany

City or town Cumberland Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred: Allegany Hospital Cumberland, Md

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cresaptown

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Frank Hite

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Myrtle ~~Hite~~ Winters Hite 6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Aug 31, 1880

8. AGE: Years	Months	Days	If less than one day
64	6	13	..... hrs. ..... min.

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Unemployed

11. Industry or business

FATHER 12. Name Wm Hite

13. Birthplace Md

MOTHER 14. Maiden name Jennie Winters

15. Birthplace Md.

16. Informant Mrs Myrtle Hite

Address Cresaptown Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 17 45 (month) (day) (year)

Cemetery or crematory Hillcrest Cem

Location Cumberland

18. Funeral director Louis Stein Inc

Address Cumberland

19. Feb. 17 1945 Winter R. Beauty M.D. (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2/14 1945 at 1:10 P. M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Feb 12 1945 to Feb 15 1945

and that I last saw h[illegible] alive on Feb 15 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	2 days
Due to arteriosclerosis cardiac	several years
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE L. Winters MD M. D. or other

Address Long Hill Date signed 2-15-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 6

CERTIFICATE OF DEATH

01242

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:
Allegany Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Pa. County: Somerset

City or town: Salisbury
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME Charles Hammond House

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Martha "Sinnett" House — 6.(c) If alive, give age: 52 years

7. Birth date of deceased (mo., day, yr.): Dec. 11, 1875

8. AGE: Years	Months	Days	If less than one day
69	1	23	...hrs. ...min.

9. Birthplace: Hampshire Co., W. Va. (Town, county, and state)

10. Usual occupation: Stone Mason

11. Industry or business: Own employer

FATHER — 12. Name: Samuel A. House

13. Birthplace: Maryland

MOTHER — 14. Maiden name: Elizabeth Farrell

15. Birthplace: Ireland

16. Informant: Charles H. House

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 8 1945 (month) (day) (year)

Cemetery or crematory: Hartley Cemetery

Location: Green Ridge Route #1

18. Funeral director: John F. Hofus

Address: Cumberland, Md.

19. Feb 8 1945 (Date rec'd by registrar) Victor R. Trantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4, 1945, at 8:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1945 to Feb 4 1945 and that I last saw h. alive on Feb 4 1945

Immediate cause of death	DURATION
Cerebro Spinal Meningitis (Epidemic)	3 days
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ...Injured at work?

23. SIGNATURE: R. H. Trevaskis, M.D. (M. D. or other)

Address: Cumberland, Md. Date signed 2/8/45

Trevaskis

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127-a)

01243

CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County ~~MINERAL~~ Allegany
City or town ~~PIEDMONT~~ Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County MINERAL
City or town PIEDMONT
(If outside city or town limits, write RURAL and give nearest town)
Street No. Tyson Street
(If rural, give LOCATION)
2.(a) If veteran, name war V

3. (a) FULL NAME HUTCHINSON, JAMES LEE

3. (b) Social Security Number 232-01-1201

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife VAN ORSDALE, FLORENCE
6.(c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.) JAN. 8, 1875

8. AGE: Years	Months	Days	If less than one day
70	1	4	....hrs. ....min.

9. Birthplace PIEDMONT, W. VA.
(Town, county, and state)
10. Usual occupation EMBALMER
11. Industry or business Funeral Service
FATHER 12. Name HUTCHINSON, JACOB
13. Birthplace WEST VIRGINIA
MOTHER 14. Maiden name POWELL, MARGARET
15. Birthplace WEST VIRGINIA
16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MD.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 14, 1945 (month) (day) (year)
Cemetery or crematory Phibs Cem
Location Westernport, Md.
18. Funeral director N. L. Rogers
Address Keyser W Va
18. Feb 12 1945 (Date rec'd by registrar) Hunter R. Trail MD Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 12, 1945 at 9.12 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-3- 1945 to 2-12- 1945
and that I last saw him alive on 2-11- 1945

	DURATION
Immediate cause of death Pulmonary embolism	1 day
Due to	
Due to	
Other conditions Benign hypertrophy prostate arteriosclerosis (Include pregnancy within 3 months of death)	

Major findings of operations Perineal prostatic resection Date of op. 2-6-45
Autopsy results Large emboles in each pulmonary artery
PHYSICIAN: Please underline the cause to which death should be charged statistically

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Howard Colvin M.D. M. D. or Other
Address Cumberland, Md. Date signed 2-12-45

DR, WILLIAMS – Dr. Johnson

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 51-C

01244

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: CUMBERLAND MD.
City or town: MEMORIAL HOSPITAL
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 DAYS
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPTTAL
How long in hospital or institution? 4DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MD. County ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 6 BROADWAY
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: WALTER C. JEFFRIES

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	SINGLE

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): JULY 15, 1920

8. AGE: Years	Months	Days	If less than one day
24	7	0	..... hrs. ..... min.

9. Birthplace: FROSTBURG ALLEGANY MD. (town, county, and state)

10. Usual occupation: OPTOMETRIST

11. Industry or business

FATHER
12. Name: WALTER JEFFRIES
13. Birthplace: MD.

MOTHER
14. Maidee name: CONNER, Emily
15. Birthplace: MD.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feby 18-45 (month) (day) (year)
Cemetery or crematory: Allegany Cem
Location: Frostburg, Md.

18. Funeral director: J. J. Hurst
Address: Frostburg Md

19. Feb. 15, 1945 (Date rec'd by registrar) Walter L. Krantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 15, 1945 at 4:A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-19- 1944 to 2-15- 1945
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Teratoma testis with metastatic tumors in lungs + brain. — DURATION: 9-10 months

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: L. Orchidectomy — Date of op. 6-26-44

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Donald L. Polson M.D.
M. D. or other
Address: Cumberland Md. Date signed 2-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

M

1

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (274)

CERTIFICATE OF DEATH

01245

Reg. Diat. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 21 Days

Hospital, institution or street address where death occurred:

618 Montgomery ave

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W VA. County HAMPSHIRE

City or town Lewis W. VA. (Rural)

(If outside city or town limits, write RURAL and give nearest town)

Street No. —

(If rural, give LOCATION)

2.(a) If veteran, name war —

3.(a) FULL NAME Catherine Taylor Johnson

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	SINGLE

6.(b) Name of husband or wife —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) 12-7-1911

8. AGE: Years	Months	Days	If less than one day
33	1	24	..... hrs. ..... min.

9. Birthplace Points Hampshire Co. W Va (Town, county, and state)

10. Usual occupation School Teacher

11. Industry or business Education

FATHER 12. Name C. T. Johnson

13. Birthplace Hampshire Co. W Va

MOTHER 14. Maiden name Leotia Fleming

15. Birthplace Simpson Taylor Co. W Va

16. Informant E. W. Brownlee

Address Springfield W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-4-45 (month) (day) (year)

Cemetery or crematory Wesley Chapel

Location Points W. Va (Rural)

18. Funeral director Ralph N. Guthrie

Address Springfield. W Va.

19. Feb. 4 1945 (Date rec'd by registrar) Winter R. Brantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 1st 1945, at 12.04 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from November 15 1944 to Feb 1 1945 and that I last saw her alive on Feb 1 1945

Immediate cause of death	DURATION
Obstruction Jaundice	3 months
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations .....

Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury Injured at work?

23. SIGNATURE T. Bailey Hunter M.D. M. D. of other

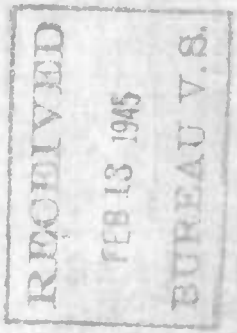
Address Cumberland Md Date signed 2/4/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

~~Bradley~~
Bailey T. Hunter



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

01246

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 9 mos. 21 da.
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 9 mos 21 da.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 716 Lyburn Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Jack Raymond Keller.

3.(b) Social Security Number: NONE

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Nov 25 1944

8. AGE: Years: — Months: 2 Days: 21 If less than one day: hrs. min.

9. Birthplace: Cumberland Md (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Billy E. Keller
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Mary Willa Price
15. Birthplace: W. Va.

16. Informant: Mrs Mary Keller
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 19 '45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland

18. Funeral director: Lowe Stein Inc.
Address: Cumberland

19. Feb 19 1945 (Date rec'd by registrar) Walter R. Krantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 16 1945, at 11:29 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-25-44 19.. to Feb 16 19 45
and that I last saw h.. alive on Feb. 16 19 45

Immediate cause of death	DURATION
Pneumonia, Infection	1 wk.
Due to: Premature birth	
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: H. E. Lowe M.D.
Address: 716 Lyburn Ave. Cumberland Md. M. D. or other
Date signed: 2/16/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

M

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (75-C)

CERTIFICATE OF DEATH

01247

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Front Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: James A. Knippenberg

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ola Shatzer Knippenberg

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): December 21, 1886

8. AGE: Years	Months	Days	If less than one day hrs. min.
58	2	0	

9. Birthplace: Allegany Co. Md.
(Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: B. & O. R.R. Co.

FATHER 12. Name: Henry Knippenberg

13. Birthplace: Germany

MOTHER 14. Maiden name: Tishua Logston

15. Birthplace: W. Va.

16. Informant: Mr. George Knippenberg

Address: 1419 OldTown Rd. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 23, 1945 (month) (day) (year)

Cemetery or crematory: Mt. Herman Cem.

Location: Williams Road

18. Funeral director: Charles L. George

Address: Cumberland, Md.

19. Feb. 23, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 21, 1945, at 6:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 16 1945, to Feb 21 1945

and that I last saw h[im] alive on February 21 1945

Immediate cause of death	DURATION
Perforations of intestines and stomach -	?
	?
Due to: Generalized Peritonitis	?
Due to: Uremia	4 days
Other conditions: Abscess of spleen	?

(Include pregnancy within 3 months of death)

Major findings of operations: Abscesses - peritonitis adhesions - Date of op. 2/17/45

Autopsy results: as above -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: [signature] M.D. or other

Address: 15 S. Liberty St. Date signed: 2/23/45

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83-a

01248

CERTIFICATE OF DEATH

Reg. Diat. No. 8

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Lonaconing (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 33 years

Hospital, institution, or street address where death occurred: St. Mary's Terrace

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing, Md. (If outside city or town limits, write RURAL and give nearest town)

Street No.: St. Mary's Terrace (If rural, give LOCATION)

2.(a) If veteran, name war: —

3. (a) FULL NAME: George Thomas Lashbaugh

3. (b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of ~~husband or~~ wife: Marion Brown Lashbaugh

6.(c) If alive, give age: 71 years

7. Birth date of deceased (mo., day, yr.): Dec 14 1874

8. AGE: Years	Months	Days	If less than one day
73	1	17	... hrs. ... min.

9. Birthplace: Barton, Allegany Co., Md. (Town, county, and state)

10. Usual occupation: Coal Miner

11. Industry or business: Althouse Company

FATHER 12. Name: Benjamin Lashbaugh

FATHER 13. Birthplace: Unknown

MOTHER 14. Maiden name: Unknown

MOTHER 15. Birthplace: Unknown

16. Informant: Mrs. Alexis Lashbaugh

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Feb 4 1945 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cemetery

Location: Lonaconing, Md.

18. Funeral director: Fry Eichhorn

Address: Lonaconing, Md.

19. Feb. 4 1945 (Date rec'd by registrar) D. E. Owings Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 1st 1945 at 9:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 16 1945, to Feb 1st 1945 and that I last saw h... alive on Jan 31st 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: Henry Wm. Hodgson M.D. M. D. or other

Address: Lonaconing, Md. Date signed: Feb 3 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (86)

CERTIFICATE OF DEATH

01248

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all his life

Hospital, institution, or street address, where death occurred:
Miners Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 43 Grant
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Ronnie Joseph Lloyd

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): May 23-1942

8. AGE: Years: 2 | Months: 8 | Days: 21 | If less than one day: hrs. min.

9. Birthplace: Frostburg - Alleg - Md.
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER
12. Name: Evan L Lloyd
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Blanch Lloyd
15. Birthplace: Frostburg, Md.

16. Informant: Evan Lloyd
Address: Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 16-1945 (month) (day) (year)

Cemetery or crematory: Allegany

Location: Frostburg Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. 2-15-45 (Date rec'd by registrar) Mrs. Stacey H. Rice Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 14 1945 (month) (day) (year), at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 12 1945 to Feb 14 1945

and that I last saw him alive on Feb 13 1945

Immediate cause of death	DURATION
Convulsions	2 Days
Due to (Under 5 yrs of age)	
Due to Underlying Cause: Undetermined. Cards.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. J. McLane Jr. M.D. (M. D. or other)

Address: Frostburg Md. Date signed: Feb 15 1945

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 73-2

CERTIFICATE OF DEATH

01250

Reg. Diat. No. 7

1. PLACE OF DEATH:

County: Allegany

City or town: Baston, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Baston
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ellen Kirk Logsdon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: James T. Logsdon

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 7, 1881

8. AGE:

Years	Months	Days	If less than one day
63	3	26	..... hrs. ..... min.

9. Birthplace: Baston Alleg. Md.
(Town, county, and state)

10. Usual occupation: Domestic

11. Industry or business: Own home

FATHER
12. Name: James Kirk
13. Birthplace: Scotland

MOTHER
14. Maiden name: Jane LaMont
15. Birthplace: Scotland

16. Informant: Mr. James Clement Logsdon
Address: Baston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 7, 1945 (month) (day) (year)

Cemetery or crematory: St. Peters Cem.

Location: Westernport, Md.

18. Funeral director: Mrs. Fay Brad Berry

Address: Westernport, Md.

19. Feb 6 1945 (Date rec'd by registrar) S. S. Boucher Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 3, 1945 at 11:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2, 1945, to Feb 3, 1945 and that I last saw h.... alive on Feb 3, 1945

	OURATION
Immediate cause of death: Cerebral Embolism	2 day
Due to: Chronic Myocarditis	2 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Norman Reuss, M. D.
M. D. or other

Address: Westernport Md. Date signed 2-5-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

DR. WILLIAMS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (73-d)

CERTIFICATE OF DEATH

Reg. Dist. No. 01251 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1 DAY

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town LONACONING
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME ALEX B. MacMILLAN

3.(b) Social Security Number 169-01-1736

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	WIDOWED

6.(b) Name of husband or wife REBECCA MacFARLAND
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUG. 7, 1872

8. AGE: Years	Months	Days	If less than one day
72	6	3	hrs. min.

9. Birthplace MARYLAND, Lonaconing, Allegany Co.
(Town, county, and state)
10. Usual occupation UNABLE TO WORK - Retired
11. Industry or business Coal Miner

FATHER
12. Name ADAM B. MACMILLAN
13. Birthplace SCOTLAND

MOTHER
14. Maiden name BARBARA GORDON
15. Birthplace SCOTLAND

16. Informant MRS. M. TERNENT
Address North BRADDOCK, PA. 816 Jones Ave.

17. Buried Date thereof Feb. 13 (month) 45 (day) 45 (year)
(Burial, cremation, or removal. Which?)
Cemetery or crematory Oak Hill Cemetery
Location Lonaconing Md

18. Funeral director W. M. Eichelberger
Address Lonaconing Md

19. Feb. 15 1945 Winter R. Frantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 10, 45, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-9-1945 to 2-10-1945 and that I last saw h. alive on 2-10-1945

	DURATION
Immediate cause of death	
Due to Chronic Myocarditis	
Due to Degeneration	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)
Major findings of operations None
Date of op. None
Autopsy results None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. F. Williams M. D. or other
Address Cumberland Date signed 2-12-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Evidence for change of age of deceased is shown on FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01252

Reg. Dist. No. 6

1. PLACE OF DEATH:

County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 52 yrs.

Hospital, institution, or street address where death occurred: 120 Church St

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 Church St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Lillian Grace Dawson Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: John A. Martin

6.(c) If alive, give age: 79 years

7. Birth date of deceased (mo., day, yr.): Feb. 4, 1873

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
72 73		4		

9. Birthplace: Kingwood, W. Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: Francis P. Dawson

13. Birthplace: Not Known

MOTHER 14. Maiden name: Not Known

15. Birthplace:

16. Informant: Miss Lola Martin

Address: 120 Church St. Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 11 1945 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: Mrs. Fay Boal Berry

Address: Westernport, Md.

19. Feb 11 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 8, 1945, at 4:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct 1, 1944 to Feb 8 1945

and that I last saw h[illegible] alive on Feb 8 1945

Immediate cause of death	DURATION
Chronic Myocarditis	2 mo
Due to: Arterio Sclerosis	1 yr
Due to:	
Other conditions: Arthritis, gall bladder disease	2 yrs.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Norman Reeves M.D. M. D. or other

Address: Westernport, Md. Date signed: 2/10/45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01253

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport Md

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 78 yrs

Hospital, institution, or street address where death occurred: 306 Philos Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No. 306 Philos Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Robert Martin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Emma Wright Martin

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1861

8. AGE: Years	Months	Days	If less than one day
83	4	17	..... hrs. ..... min.

9. Birthplace: Hampshire Mineral, W. Va.

(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal mine

FATHER 12. Name: Joseph Martin

13. Birthplace: Scotland

MOTHER 14. Maiden name: Catherine Johnson

15. Birthplace: Scotland

16. Informant: Mr. Frederick Martin

Address: 306 Philos Ave. Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Dec. 14 1945 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport Md

18. Funeral director: Mrs Tate Boal Berry

Address: Westernport, Md.

19. 12-14-45 (Date rec'd by registrar) 19 [illegible] Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Dec. 11, 1945, at 3:05 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive, on ..... 19.....

	DURATION
Immediate cause of death: Chronic myocarditis	14 yr
Due to: Arteriosclerosis	10 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P E Berry M.D. M. D. or other

Address: Piedmont W Va Date signed 12/13/45

Lee Grove

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83a)

CERTIFICATE OF DEATH

01254

Reg. Dist. No. 4

1. PLACE OF DEATH:

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or Institution? 42 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town GILMORE (Near Midland)
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME JAMES J. McGOYE

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	MARRIED

6.(b) Name of husband or wife JAME WINNERS McGOYE

6.(c) If alive, give age 64 years

7. Birth date of deceased (mo., day, yr.) JAN. 7, 1873

8. AGE: Years	Months	Days	If less than one day
72	0	25	hrs. min.

9. Birthplace Mt. Savage, Allegany Co., Md.
(Town, county, and state)

10. Usual occupation Coal Miner

11. Industry or business Jackson Mine

FATHER 12. Name Michael McGOYE

13. Birthplace IRELAND

MOTHER 14. Maiden name ELIZABETH FARRELL

15. Birthplace IRELAND

16. Informant Mrs. James Munday

Address Cumberland, Md.

17. Burial Date thereof Feb 5 1945
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Belvedere Cem

Location Midland, Md.

18. Funeral director W. Eccleston

Address Lonaconing, Md

19. Feb 5, 1945 Walter L. Brantz, M.D.
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEB. 2, 1945 19 at 9:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 22, 1944 to Feb. 2, 1945 and that I last saw h. alive on Feb. 2, 1945

Immediate cause of death	DURATION
Cerebral hemorrhage	Dec. 1944
Hypertension left leg.	Dec. 1944
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE D. B. Jones M.D.
M. D. or other

Address Medical Bldg Cumberland Date signed 2-5-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01255

CERTIFICATE OF DEATH

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
Douglas Avenue
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Church Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Minnie McGuire

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Thomas McGuire
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 30, 1893

8. AGE: Years: 51 | Months: 10 | Days: 8 | If less than one day: hrs. min.

9. Birthplace: Lonaconing, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own Home

FATHER
12. Name: Gustavus Eichhorn
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Martha Atkinson
15. Birthplace: Lonaconing, Md.

16. Informant: George F. Eichhorn
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 9, 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: Dr. Eichhorn
Address: Lonaconing, Md.

19. Feb. 9 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 6, 1945 at 8:15 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1944 to Feb. 6 1945 and that I last saw h.. alive on Feb. 4 1945

Immediate cause of death	DURATION
Cancer of rectum	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M. D.
M. D. or other
Address: Lonaconing, Md. Date signed: Feb. 10 1945

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 74a

CERTIFICATE OF DEATH

01256

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1. PLACE OF DEATH:
County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address, where death occurred: R.D.#3 ~~Cumberland~~ Hagen Road
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Rural Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: R.D.#3 Cumberland Road
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Hanson A. Miller

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Sallie Donnelly Miller
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug. 31, 1873

8. AGE: Years	Months	Days	If less than one day
71	5	12	hrs. min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: General Work (odd jobs)
11. Industry or business: Liberty Cleaning Co.

FATHER
12. Name: Camuel Miller
13. Birthplace: Maryland

MOTHER
14. Maiden name: Ella Dicken
15. Birthplace: Maryland

16. Informant: Mr. Lester Miller
Address: R.D.#3 Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 17, 1945 (month) (day) (year)
Cemetery or crematory: Zion Memorial Cem.
Location: Near Cumberland, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Feb 17 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 12th, 1945, at about 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Pierce H. Lotus, M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 2-15-45

Deputy Medical Examiner - Allegany Co.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01257

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 60 yrs

Hospital, institution, or street address where death occurred: 173 S. Mechanic St.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: 173 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Sophia Anna Miller

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: John P. Miller

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): Oct 20 1884

8. AGE: Years	Months	Days	If less than one day
60	3	21	..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER

12. Name: John Henry Brack

13. Birthplace: Germany

MOTHER

14. Maiden name: —

15. Birthplace: —

16. Informant: Wm. E. Eichner

Address: Cumberland Md.

17. Burial (Burial, cremation, or removal, Which?) Date thereof: Feb. 14 45 (month) (day) (year)

Cemetery or crematory: Hillcrest Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Sons

Address: Cumberland

19. Feb. 14 1945 (Date rec'd by registrar) Walter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 11th., 1945 at 3 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op. .....

Autopsy results: No Autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Pierce H. Lonsaw M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 2-12-45

Deputy Medical Examiner - Allegany Co.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13)

01258

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 50 yrs
Hospital, institution, or street address where death occurred: 714 Riverview Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 714 Riverview Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Margaret Theresa Dinke

3. (b) Social Security Number: None

4. Sex	5. Color or race	6. Single, married, widowed, or divorced
Female	White	Widowed.

6.(b) Name of husband or wife: Anthony A. Dinke
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug 26 1874

8. AGE:

Years	Months	Days	If less than one day
70	5	26	hrs. min.

9. Birthplace: Ingrisdale Pa
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business:
FATHER 12. Name: Richard Stipp
13. Birthplace: Pa
MOTHER 14. Maiden name: Mary Stasler
15. Birthplace: Pa.
16. Informant: Mrs Mary Shoemaker.
Address: 714 Riverview Place
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 24 45 (month) (day) (year)
Cemetery or crematory: St Peter & Paul Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. Feb. 23, 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 22 1945, at 10:50 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 10 1944, to Feb 22 1945
and that I last saw h— alive on Feb. 21 1945

Immediate cause of death	DURATION
Uremia Coma	2 days
Due to: Cerebral Hemorrhage Bronchus	May 44
Due to: Nephritis	2 yrs
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Thos A. Foord M. D. or other
Address: Cumberland Md Date signed: Feb 23/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01259

Reg. Dist. No. 10

M

1

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 8 months
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Mt Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Main St
(If rural, give LOCATION)
2.(a) If veteran, name war:

3. (a) FULL NAME: Nann Moseley

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W.	Married

6.(b) Name of husband or wife: Wm E. Moseley
6.(c) If alive, give age: 62 years

7. Birth date of deceased (mo., day, yr.): Oct 8 - 1890

8. AGE: Years	Months	Days	If less than one day
54	4	16	...hrs. ...min.

9. Birthplace: Ohio (Town, county, and state)
10. Usual occupation: Home Wife
11. Industry or business:
FATHER 12. Name: Barton B Stewart
13. Birthplace: Pit City Pa
MOTHER 14. Maiden name: Sarah Kelley
15. Birthplace: Pit City Pa
16. Informant: Wm E. Moseley
Address: Mt Savage
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb - 28 - 45 (month) (day) (year)
Cemetery or crematory: Methodist
Location: Mt Savage
18. Funeral director: J J Hunt
Address: Frostburg
19. Feb. 27 1945 Vernon McDermott Registrar
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25th., 1945 at about 9.30P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ...19..., to ...19...
and that I last saw h... alive on ...19...

Immediate cause of death	DURATION
Suicide by gunshot	Instant death
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: suicide Date of: 2-25-45
Where did injury occur? Mt. Savage, Allegany, Md. (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): home
Means of injury: 32 Cal. revolver Injured at work? no

23. SIGNATURE: Phineas H. Brown, M.D. M. D. or other
Address: Cumberland, Maryland Date signed: 2-26-45
Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-E)

02220

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 744 Maryland Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Mrs. Sallie Neff

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: George R. Neff
6.(c) If alive, give age ..... years

7. Birth data of deceased (mo., day, yr.): Feb. 12, 1867

8. AGE: Years	Months	Days	If less than one day
78	0	2	..... hrs. ..... min.

9. Birthplace: Grantsville, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business

FATHER
12. Name: Albert Bickfoed
13. Birthplace: Maryland

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Frank S. Neff
Address: 744 Maryland Ave. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 16, 1945 (month) (day) (year)
Cemetery or crematory: Grantsville Cemetery
Location: Grantsville, Md.

18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Feb. 16, 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14, 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 11 1945, to Feb 12 1945
and that I last saw h.... alive on Feb 12 1945

Immediate cause of death	DURATION
Chronic nephritis	
Chronic Myocarditis	
Due to: Senility	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: Cumberland Date signed 2/15/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

4037722
Frost

01260

Reg. Diat. No. 2

1. PLACE OF DEATH:
County: Allegany
City or town: Twiggtown
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Twiggtown
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland (Rural)
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Twiggtown, Md.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Albert Ellsworth Newell

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Stacha Robinette
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug 11, 1863

8. AGE: Years	Months	Days	If less than one day
81	6	8	..... hrs. ..... min.

9. Birthplace: Twiggtown Allegany Co. Md
(Town, county, and state)
10. Usual occupation: Merchant
11. Industry or business: Grocery Store

FATHER
12. Name: John W. Newell
13. Birthplace: Connecticut

MOTHER
14. Maiden name: Amy - [illegible] Rice
15. Birthplace: Twiggtown Md.

16. Informant: Addie M. Newell
Address: R.F.D #2 Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 21 1945 (month) (day) (year)
Cemetery or crematory: Hillcrest Cemetery
Location: Cumberland Md

18. Funeral director: John D. Hafer
Address: Cumberland Md

19. Feb 23 1945 (Date rec'd by registrar) D Bennett Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 19, 1945, at 4:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 18, 1945, to Feb. 19, 1945, and that I last saw him alive on February 18, 1945

Immediate cause of death	DURATION
Cerebral Hemorrhage	
(right) as a proximate	1 day
Due to: left side body.	
Due to: #	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Stanley Jankowski M. D. or other
Address: 15 S. Liberty St. Date signed: 2/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians, please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

01261

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: North Branch near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Flintstone Gap

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME: George Marshall Nixon

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Ella R. Arnold

6.(c) If alive, give age: 70 years

7. Birth date of deceased (mo., day, yr.): Oct 13, 1861

8. AGE:

Years	Months	Days	If less than one day
83	4	11	...hrs. ...min.

9. Birthplace: Oldtown, Allegany Co., Md.
(Town, County, and State)

10. Usual occupation: Tinsman (Retired)

11. Industry or business: W. Md.

FATHER
12. Name: John Nixon
13. Birthplace: Oldtown, Md.

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Geo. H. Nixon
Address: 735 Oldtown Rd - Cumb. Md.

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Feb 27, 1945
(month) (day) (year)

Cemetery or crematory: Davis Memorial Cemetery

Location: Oldtown Road - Cumberland Rt 6

18. Funeral director: John J. Hafer

Address: Cumberland, Md.

19. Feb 26 1945
(Date rec'd by registrar)

Hunted R. Trout, Md.
Registrar

M. E. P. Cumbo

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1945 at M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 26 1945 to Feb 1945 and that I last saw her alive on Feb 24 1945

	DURATION
Immediate cause of death: Coronary Occlusion	1/2 hour
Due to: Arterio sclerosis	4 yrs
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. R. Owens M. D. or other

Address: 139 Va. Ave. Date signed: 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (MC)

01262

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 15 yrs.
Hospital, institution or street address where death occurred: 77 Lang Ave.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 77 Lang Ave.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Ruth Eleanor Ott

3.(b) Social Security Number: 220-03-7236

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Paul Ott
6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): April 19 1905

8. AGE: Years	Months	Days	If less than one day
39	10	5	...hrs. ...min.

9. Birthplace: Va.
(Town, county, and state)
10. Usual occupation: Clerk
11. Industry or business: Dept. Store
FATHER 12. Name: S. Yost McDonald.
13. Birthplace: Pa
MOTHER 14. Maiden name: Laura Lantz
15. Birthplace: Pa
16. Informant: Paul Ott
Address: Cumberland
17. Burial, cremation, or removal. Which? Burial & Removal Date thereof: Feb 25 45 (month) (day) (year)
Cemetery or crematory: Oakland Cem.
Location: Oakland, Md.
18. Funeral director: Louis Stein Inc
Address: Cumberland.
19. Feb. 24 1945 (Date rec'd by registrar) Vinton E. Daty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 24 1945 at 2 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 1 1945 to Feb 24 1945
and that I last saw h.. alive on Feb. 12 1945

Immediate cause of death	DURATION
Acute Myocardial Failure	1 hour
Due to: Rheumatic Heart Disease Mitral Stenosis & Incompetency	7 Years
Due to: Carter Stenosis	10 Years
Auricular Fibrillation	
Other conditions: Enlarged Liver	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results: —
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: [signature] M. D. or other
Address: 15 S Liberty St. Date signed: 2/24/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (18-a)

CERTIFICATE OF DEATH

01263

Reg. Dist. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Miners Hospital
How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Midlothian
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Raymond Woodrow Parry

3.(b) Social Security Number: 217-10-6064

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	married

6.(b) Name of husband or wife: Rosalie Parry
6.(c) If alive, give age: 27 years

7. Birth date of deceased (mo., day, yr.): June 12, 1913

8. AGE: Years: 31 | Months: 7 | Days: 20 | If less than one day: hrs. min.

9. Birthplace: Midlothian Allegany Cty. Md.
(Town, county, and state)

10. Usual occupation: Labratory Worker

11. Industry or business: Celanese Corporation

FATHER
12. Name: Frank Parry
13. Birthplace: England

MOTHER
14. Maiden name: Sarah Carpenter
15. Birthplace: England

16. Informant: Mrs. Raymond Parry
Address: Midlothian, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 5 1945 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg Md

18. Funeral director: J. J. Obrist
Address: Frostburg Md.

19. 2-5-45 (Date rec'd by registrar) Miss Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 2 1945, at 9 30 AM

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from Jan 31 1945 to Feb 2 1945 and that I last saw h... alive on Feb 2 1945

	DURATION
Immediate cause of death: Rupture of Left diaphram with herniation of stomach into left	Since Dec 4 1944
Due to: Pleural Cavity	4 Day
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: accident Date of: Dec 4 1944
Where did injury occur? (City or town) Yaxtell (County) Md (State)
Injured at home, farm, industry, public place (where?): while hunting
Means of injury: Fell & Struck by Gun Injured at work? no

23. SIGNATURE: W. M. C. Lane Jr. M.D.
M. D. or other
Address: Frostburg Md Date signed: 2-5-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23)

CERTIFICATE OF DEATH

01264

Reg. Diat. No. 9

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? all her life

Hospital, Institution, or street address where death occurred: 38 W. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 38 W. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Annie E. Porter

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: None

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): June 5 1854

8. AGE: Years: 90 Months: 8 Days: 6 If less than one day: hrs. min.

9. Birthplace: Frostburg, Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: ---

FATHER 12. Name: Levi B. Porter

13. Birthplace: Frostburg Md.

MOTHER 14. Maiden name: Rachel A. Keisinger

15. Birthplace: Unknown

16. Informant: Scott Porter

Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 13 1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: J. J. Diehl

Address: Frostburg Md.

19. Feb 12 1945 Mrs. Nancy N. Rose (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 10 1945, at 9 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-6 1945, to 2-10 1945

and that I last saw her alive on 2-10 1945

Immediate cause of death	DURATION
Hypertensive cardio-vascular disease.	
Due to	
Due to Arterio-sclerosis.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: X Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, Industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other

Address: Frostburg, Md. Date signed: 2/12/45

Dr. Topper

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-1)

CERTIFICATE OF DEATH

01265

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: ALLEGANY
City or town: CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 10 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: PA. County: BEDFORD
City or town: HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME: MRS. IDA RINEHART

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	MARRIED

6.(b) Name of husband or wife: JOHN RINEHART
6.(c) If alive, give age: 86 years
7. Birth date of deceased (mo., day, yr.): SEPTEMBER 6, 1860

8. AGE: Years	Months	Days	If less than one day
84	5	1	hrs. min.

9. Birthplace: [illegible] Aurora, West Virginia (Town, county, and state)
10. Usual occupation: HOUSEWIFE
11. Industry or business: Own Home

FATHER
12. Name: LOUIS GLADWELL
13. Birthplace: PA.

MOTHER
14. Maiden name: BELINDA WOTRING
15. Birthplace: W. VA.

16. Informant: MEMORIAL HOSPITAL
Address: CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 11, 1945 (month) (day) (year)
Cemetery or crematory: Lutheran Cem
Location: Aurora, W Va
18. Funeral director: Wayne C. Yingling
Address: Davis, W. Va.
19. Feb. 11, 19 45 (Date rec'd by registrar) Walter R. Beauty M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: FEBRUARY 7, 19 45 at 11:20 P.M.
21. I CERTIFY that death occurred on the date above stated: that I attended deceased from [illegible] 19 to 19
and that I last saw h[illegible] alive on 19
Immediate cause of death: Chronic Arteris — DURATION
Sclerotic Heart disease 15 yrs
Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John A Topper MD
M. D. or other
Address: Hyndman Pa Date signed 2/9/45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01266

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? ✓ 40 yrs
Hospital, institution, or street address where death occurred: 145 Winecow St
How long in hospital or institution? ✓

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 145 Winecow ST.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Edward Robinson

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored ✓	Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 14 1869

8. AGE: Years: 75 | Months: 11 | Days: 0 | If less than one day: hrs. min.

9. Birthplace: Blackstone Va.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: Edward Robinson
13. Birthplace: Va.

MOTHER
14. Maiden name: Maria Bowles
15. Birthplace: Va

16. Informant: Walter Robinson - 16-W 133rd St.
Address: New York. N.Y

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 19 1945 (month) (day) (year)
Cemetery or crematory: Sumner Cemetary
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md.

19. Feb 19 (Date rec'd by registrar) 19 45 Walter R. Mauty M.D. Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: February 14th., 19 45, at 12:30 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Thrombosis	
Due to	
Due to	
Other conditions: Old Osteo-myelitis right Femur. (Include pregnancy within 3 months of death)	5 yrs

Major findings of operations: ---
Date of op.:
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Prince H. Johnson M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 2-15-45
County Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (47-d)

CERTIFICATE OF DEATH

01267

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 30 mo
Hospital, Institution, or street address where death occurred: 742 Baker St.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 742 Baker St.
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Walter Calvin Reighard

3.(b) Social Security Number: 214-05-4857

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

8.(b) Name of husband or wife: Bertha Wise
8.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Feb 16 1882

8. AGE: Years	Months	Days	If less than one day
63	0	11	hrs. min.

9. Birthplace: Pa.
(Town, county, and state)
10. Usual occupation: Treasurer Office employee
11. Industry or business: Brewery
FATHER 12. Name: David Reighard
13. Birthplace: Pa.
MOTHER 14. Maiden name: Clara Lysinger
15. Birthplace: Pa.
16. Informant: Mrs Bertha Wise Reighard
Address: Cumberland Rd.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2 45 (month) (day) (year)
Cemetery or crematory: Hillcrest Cem
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland
19. Mar 2 1945 (Date rec'd by registrar) Walter R. Beauty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: F. 27. 1945 at 7:20 PM
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from F. 28. 1944 to F. 27 1945
and that I last saw him alive on F. 25, 1945
Immediate cause of death: Carcinoma of Lung — DURATION
Due to:
Due to:
Other conditions: Chronic Valvular Heart Disease
(Include pregnancy within 3 months of death)
Major findings of operations: none
Date of op. none
Autopsy results: none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: W. F. Williams M. D. or other
Address: Cumberland Date signed F-28-45

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01268

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 day

Hospital, institution, or street address where death occurred:

Allegany Hospital

How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Penna. County: Bedford

City or town: Hyndman

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war: V

3.(a) FULL NAME: Harry Turner Schilling

3.(b) Social Security Number: 208-10-5806

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Clara E. McNeer

6.(c) If alive, give age: 65 years

7. Birth date of deceased (mo., day, yr.): February 12, 1880

8. AGE: Years: 65 | Months: | Days: 16 | If less than one day: hrs. min.

9. Birthplace: Mifflin Co. Penna.
(Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business: Penna. Lumber and Post Co.

FATHER 12. Name: Aaron Schilling

13. Birthplace: Pa.

MOTHER 14. Maiden name: Malinda Wagner

15. Birthplace: Pa.

16. Informant: Mrs. Clara Schilling

Address: Hyndman, Pa.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar. 4 1945 (month) (day) (year)

Cemetery or crematory: Berlin I.O.O.F.

Location: Berlin, Pa.

18. Funeral director: Harvey N. Zeigler

Address: Hyndman, Pa.

19. Mar 5 1945 (Date rec'd by registrar) Walter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 2/28 1945, at 7:15 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 2/27 1945, to 2/28 1945 and that I last saw him alive on 2/28 1945

Immediate cause of death	DURATION
Coronary Thrombosis	8 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: John A. Topper M.D.
M. D. or other

Address: Hyndman, Pa. Date signed: 3-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

01269

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 1 yr.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 105 Grand Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Willie Blanche Scott

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Dec. 13 1935

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
9	2	11		

9. Birthplace: Romleysburg W. Va.

(Town, county, and state)

10. Usual occupation: student

11. Industry or business:

FATHER — 12. Name: Herman B Scott

13. Birthplace: W. Va.

MOTHER — 14. Maiden name: Ursle Bulford

15. Birthplace: W. Va.

16. Informant: Herman B Scott

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 27 (month) (day) 45 (year)

Cemetery or crematory: Rose Hill Cem

Location: Cumberland

18. Funeral director: Lowe's Stein Serv

Address: Cumberland

19. Feb 27 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 24 1945, at 7:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 20 1945 to Feb 24 1945 and that I last saw her alive on Feb 24 1945

Immediate cause of death	DURATION
Diabetis Comma acute.	3 days
Due to: Diabetis	3
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: M. D. or other

Address: 133 Va Ave Date signed: 2-26-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (108)

CERTIFICATE OF DEATH

01270

Reg. Diat. No. 4

1. PLACE OF DEATH:
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 57 yrs.
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 5 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 513 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John Henry Sell

3.(b) Social Security Number 214-14-7845

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Helen Inc Connell
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 24 1887

8. AGE: Years	Months	Days	If less than one day
57	9	25	..... hrs. ..... min.

9. Birthplace Cumberland Md.
(Town, county, and state)
10. Usual occupation Contractor
11. Industry or business Building
FATHER 12. Name Michael Sell
13. Birthplace Cumberland Md
MOTHER 14. Maiden name Margaret Warner
15. Birthplace Md
16. Informant Mrs. C. Sell
Address Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 21 45 (month) (day) (year)
Cemetery or crematory St. Peter & Paul's
Location Cumberland
18. Funeral director Louis Stein Inc
Address Cumberland
19. Feb. 21, 1945 (Date rec'd by registrar) Walter R. Trautz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 19, 1945 at 4:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2-14-45 19.. to 2-19-45 19.. and that I last saw him alive on Feb. 18 1945

Immediate cause of death	DURATION
Acute myocarditis	Several days
Due to Pleuro-pneumonia	1 week
Due to Pulmonary edema	2 days
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE C. C. Zimmerman M. D. or other
Address Cumberland, Md. Date signed 2-20-45

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

CERTIFICATE OF DEATH

01271

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 47 yrs.

Hospital, institution, or street address where death occurred:

6 Elder St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 6 Elder St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Peter Shaffer

3.(b) Social Security Number 705-05-4794

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Ella Virginia Bedford

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept 3 1866

8. AGE: Years	Months	Days	If less than one day
78	5	7	..... hrs. ..... min.

9. Birthplace: Martinsburg, Berkeley W. Va (Town, county, and state)

10. Usual occupation: Retired Machinist

11. Industry or business: B & O. Railroad

FATHER 12. Name: Simon Peter Shaffer

FATHER 13. Birthplace: Martinsburg W. Va

MOTHER 14. Maiden name: Susan K. Betz

MOTHER 15. Birthplace: Martinsburg W. Va

16. Informant: Dorothy Bryant

Address: 6 Elder St - Cumb. Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 13 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland Md.

18. Funeral director: John J. Hafer

Address: Cumberland Md.

19. Feb. 13 1945 (Date rec'd by registrar) Wade A Frantz Registrar

M. & B. Embalmers

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 10 1945 at 6:30 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1944 to Feb 10 1945 and that I last saw h... alive on Feb 10 1945

Immediate cause of death	DURATION
Cerebral Apoplexy	
Due to Cardio Vascular	9 Yrs
Disease	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: M. D. Owens M. D. or other

Address: 139 Virginia Date signed 2/12/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

01272

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 yrs.
Hospital, institution, or street address where death occurred:
119 Harrison St.
How long in hospital or institution: -

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: W. Va. County: Preston
City or town: Rowelsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: WORLD WAR I

3.(a) FULL NAME: Emory Shatzer

3.(b) Social Security Number: 705-05-1800

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
male	white	married.

6.(b) Name of husband or wife: Nellie Rhoades
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 21. 1889

8. AGE: Years	Months	Days	If less than one day
55	4	2	..... hrs. ..... min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)
10. Usual occupation: Foreman.
11. Industry or business: Water & Pipe Dept. B. & O. R.R.

FATHER
12. Name: Conrad Shatzer
13. Birthplace: Md.

MOTHER
14. Maiden name: Sidney Danials
15. Birthplace: Md.

16. Informant: Carl Shatzer.
Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 25 1945 (month) (day) (year)
Cemetery or crematory: Rose Hill Cemetary
Location: Cumberland, Md.

18. Funeral director: Louis Stein, Inc.
Address: Cumberland, Md

19. 2/24/45 (Date rec'd by registrar) 19 ..... Winter R. Dantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 23rd, 1945, at about 5 A: M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: --
Date of op. .....
Autopsy results: no autopsy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Phillip H. Brown, M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 2-23-45

Deputy Medical Examiner - Allegany Co.

Dr. Williams

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (Md)

CERTIFICATE OF DEATH

01273

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 58
Hospital, institution, or street address where death occurred:
Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 112 Washington Street
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. John G. Shearer

3.(b) Social Security Number: 214-05-4858

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Henrietta Holton
6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): February 1 1887

8. AGE: Years: 58 | Months: 0 | Days: 24 | If less than one day: hrs. min.

9. Birthplace: ~~Maryland~~ Cumberland Md.
(Town, county, and state)

10. Usual occupation: Supply Clerk

11. Industry or business: Defense Plant

FATHER
12. Name: Robert Shearer
13. Birthplace: Virginia

MOTHER
14. Maiden name: Margaret Goshorn
15. Birthplace: West Virginia

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 28 45 (month) (day) (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland.
18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. Feb. 28 1945 (Date rec'd by registrar) Vinton R. Dant M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 25 1945, at 11:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-xx-1943 to 2-25-1945 and that I last saw him alive on 2-25-1945

	DURATION
Immediate cause of death: Cerebral Thrombosis	2 days
Due to: Coronary Arteriosclerosis, Chronic Myocardial Degeneration	
Due to:	
Other conditions: Left Bundle Branch Block.	

(Include pregnancy within 3 months of death)

Major findings of operations: None
Date of op.: None
Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: John F. Williams M. D. or other
Address: Cumberland Md. Date signed: 2/26/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

01274

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miner's Hospital

How long in hospital or institution? 9 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Allegany

City or town Frostburg

(If outside city or town limits, write RURAL and give nearest town)

Street No. 44 E. Union St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Charles Joseph Shields

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife Margaret Kenny

6.(c) If alive, give age 75 years

7. Birth date of deceased (mo., day, yr.) December 18, 1869

8. AGE: Years	Months	Days	If less than one day
75	1	24	hrs. min.

9. Birthplace Shaft, Allegany, Md. (Town, county, and state)

10. Usual occupation Janitor

11. Industry or business St. Michaels Church

FATHER 12. Name James Shields

13. Birthplace Ireland

MOTHER 14. Maiden name Margaret Bean

15. Birthplace England

16. Informant Mrs. Katherine Arnold

Address R.F.D. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2-15-1945 (month) (day) (year)

Cemetery or crematory St. Michaels Cemetery

Location Frostburg, Md.

18. Funeral director Jacob Dagler

Address Frostburg, Md.

19. 2-14-45 Mrs. Nancy H. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 11 1945 at 2:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 2 1945, to Feb 11 1945

and that I last saw him alive on Feb 11 1945

Immediate cause of death	DURATION
3rd Degree Burns Legs & Back	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 2-2-45

Where did injury occur? Frostburg (City or town) alley (County) Md (State)

Injured at home, farm, industry, public place (where?) St. Michaels Hall

Means of injury Clothes caught on fire Injured at work? Yes

23. SIGNATURE Thos. McCune Jr. M.D. or other

Address Frostburg Md Date signed 2-13-45

(M)

(1)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01275

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred: 96 E. Main Street

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md. County: Baltimore

City or town: Baltimore (If outside city or town limits, write RURAL and give nearest town)

Street No. 317 Park Ave. Balto. Md. (If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3.(a) FULL NAME: John Cuddy Francis Shields

3.(b) Social Security Number: 214-07-2001

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Emma Thomas

6.(c) If alive, give age: 29 years

7. Birth date of deceased (mo., day, yr.): Feb - 25 - 1909

8. AGE:

Years	Months	Days	If less than one day
35	11	24	...hrs. ...min.

9. Birthplace: Frostburg, Allegany, Md. (Town, county, and state)

10. Usual occupation: Hotel Clerk

11. Industry or business

FATHER

12. Name: Charles Shields

13. Birthplace: Borden Shaft, Md.

MOTHER

14. Maiden name: Margaret Toomey

15. Birthplace: Borden Shaft, Md.

16. Informant: Mrs. Emma Shields

Address: 317 Park Ave. Balto. Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2-27-1945 (month) (day) (year)

Cemetery or crematory: St. Michaels Cemetery

Location: Frostburg, Md.

18. Funeral director: Jacob F. Draper

Address: Frostburg, Md.

19. 2-21-45 Miss Nancy N. Roe (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 19 1945 at 4:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 14 1945, to Feb 19 1945, and that I last saw him alive on Feb 14 1945

Immediate cause of death	DURATION
Pulmonary Tuberculosis	3 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ...Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury: ...Injured at work?

23. SIGNATURE: W. M. McLane Jr. M.D. M. D. or other

Address: Frostburg Md. Date signed: Feb 20 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Outside of City limits

(M)

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

01276

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Rural #3 Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 Yr 10 Mo 14 Days

Hospital, institution, or street address where death occurred:
Rural # 3. Cumberland, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural # 3. Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.: Rural # 3.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Thomas David Shipley

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife:

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 18, 1942

8. AGE: Years	Months	Days	If less than one day
2	10	14	hrs. min.

9. Birthplace: Cumberland, Allegany Co, Maryland
(Town, county, and state)

10. Usual occupation:

11. Industry or business:

FATHER — 12. Name: James T. Shipley

13. Birthplace: Cumberland, Md.

MOTHER — 14. Maiden name: Lela Slaubaugh

15. Birthplace: Horse Shoe Run, W. Va.

16. Informant: Mrs. James T. Shipley

Address: Rt # 3. Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 2/6/45 (month) (day) (year)

Cemetery or crematory: Greenmount Cemetery

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb 4, 1945 (Date rec'd by registrar) Wm. R. Beatty M.D. Registrar

MEDICAL CERTIFICATION about A.

20. DATE OF DEATH: February 2nd., 1945, at 1:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Broncho-Pneumonia	about 1 week
Due to	
Due to	
Other conditions ---	

(Include pregnancy within 3 months of death)

Major findings of operations: --

Date of op.:

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Phillip H. Bowen, M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 2-3-45

Deputy Medical Examiner for Allegany Co

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH

01277

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 517 N. Center St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Leo Casper Shober

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	

6.(b) Name of husband or wife: Winifred Crawford

6.(c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.): Apr 10, 1904

8. AGE: Years	Months	Days	If less than one day
40	10	17	...hrs. ...min.

9. Birthplace: Cumberland Allegany Co. Md (Town, county, and state)

10. Usual occupation: Tavern Operator

11. Industry or business

MOTHER FATHER

12. Name: John C. Shober

13. Birthplace: Cumberland Md.

14. Maiden name: Rachael Welsh

15. Birthplace: Everett Pa

16. Informant: Oscar Shober

Address 503 N. Mechanic St Cumb.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Mar 2, 1945 (month) (day) (year)

Cemetery or crematory St Peters & Paul Cemetery

Location Cumberland, Md.

18. Funeral director John J. Haller

Address Cumberland, Md

19. March 1 1945 (Date rec'd by registrar) Hunter R. Trantz M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 27, 1945, at 11:40 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from December 1 1944 to February 27 1945

and that I last saw h... alive on February 22 1945

	DURATION
Immediate cause of death: Congestive heart failure	3 Months
Due to: chronic myocarditis	several years
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op. ...

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE W. Brinn M.D. M. D. or other

Address Lonaconing, Md. Date signed 2-28-45

L. Brings-

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01278

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 mos.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 2 mos.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: W Va County: Barkley

City or town: Paw Paw

(If outside city or town limits, write RURAL and give nearest town)

Street No.:

(If rural, give LOCATION)

2.(a) If veteran, name war: ✓

3. (a) FULL NAME: Mary E. Shocks

3. (b) Social Security Number: none

4. Sex: Female

5. Color or race: White

6. If Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Lewis L Shocks

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 23 1880

8. AGE: Years: 64 Months: 9 Days: 14 If less than one day: hrs. min.

9. Birthplace: Augusta Va. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER 12. Name: George N Arnold

13. Birthplace: W. Va.

MOTHER 14. Maiden name: Rebecca Kesler

15. Birthplace: W. Va

16. Informant: Lewis L Shocks

Address: Paw Paw, W. Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 10 45 (month) (day) (year)

Cemetery or crematory: Camp Hill Cem

Location: Paw Paw W. Va

18. Funeral director: Lewis Stein Inc

Address: Cumberland

19. Feb 9 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 7 1945 at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-29 — 1944 to 2-6 1945

and that I last saw her alive on 2-6 1945

Immediate cause of death	DURATION
Malignancy of Uterus	6 mos.
Due to: Malignancy of Breast	3 yr.
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: P. L. Bowen M.D. M.D. or other

Address: Cumberland Md Date signed: 2-7-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01279

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Near Lonaconing - Davis Int.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Lonaconing - Davis Int.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Peter Smith

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): April 3, 1863

8. AGE: Years	Months	Days	If less than one day
81	10	19	... hrs. ... min.

9. Birthplace: Lonaconing Allegany Co. Md.
(Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business: Own Farm
FATHER 12. Name: John Smith
FATHER 13. Birthplace: Germany
MOTHER 14. Maiden name: Catherine Meisel
MOTHER 15. Birthplace: Germany
16. Informant: Mrs. Annie Pfrengel
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 2 1945 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: C. C. Eichhorn
Address: Lonaconing, Md.
19. March 5 1945 (Date rec'd by registrar) D. E. Donaldson Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: about February 22nd., 1945, at unknown M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ... 19..., to ... 19...
and that I last saw h... alive on ... 19...

Immediate cause of death: Coronary Occlusion — DURATION:

Due to: (Last seen alive ten days ago;

Due to: Head, thoracic contents, left arm partially devoured by animals, presumably rats; possibly by a pet dog, who was in the room with him)

Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Pierre H. Bowen M.D.
M. D. or other
Address: Cumberland, Maryland Date signed: 3-1-45

Deputy Medical Examiner - Allegany Co.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B'a)

01280

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 117 Bowery
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Charles Melvin Smouse

3.(b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct. 16, 1872

8. AGE:

Years	Months	Days	If less than one day
72	3	28	hrs. min.

9. Birthplace: Frostburg-Alleg-Md. (Town, county, and state)
10. Usual occupation: retired
11. Industry or business: coal mine laborer

FATHER
12. Name: Daniel Smouse
13. Birthplace: Grantville, Md.

MOTHER
14. Maiden name: Mary Hitchins
15. Birthplace: Wales

18. Informant: Miss Eva Smouse
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 16-1945 (mnnth) (day) (year)
Cemetery or crematory: Allegany
Location: Frostburg, Md.

18. Funeral director: H. C. Diehl
Address: Frostburg

19. 2-16 1945 Mrs. Harvey L. Rose
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14 1945 at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1944 to Feb. 14 1945
and that I last saw him alive on Feb. 14 1945

Immediate cause of death	DURATION
Cardio-vascular renal disease.	10 yrs.
Due to arterio-sclerosis.	
Due to senility.	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: X Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? X (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: H. C. Diehl, M. D.
M. D. or other
Address: Frostburg, Md. Date signed 2/15/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01281

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 73 years

Hospital, Institution, or street address where death occurred: 311 Holland St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 Holland St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3. (a) FULL NAME: Henry Adam Spies

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Daisy V Hoenicke

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Aug 9 1871

8. AGE:

Years	Months	Days	If less than one day
73	5	28	...hrs. ...min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Caretaker - Cemetery

11. Industry or business: Retired 10 yrs.

FATHER 12. Name: Anthony Spies

13. Birthplace: Ohio

MOTHER 14. Maiden name: Mary Mieland

15. Birthplace: Md.

16. Informant: Harry A Spies

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 9 45 (month) (day) (year)

Cemetery or crematory: St Lukes Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Sons.

Address: Cumberland

19. Feb. 9 1945 (Date rec'd by registrar) Walter R. Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 6, 1945 at 8:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Oct. 15, 1944, to Feb. 6, 1945 and that I last saw him alive on Feb. 6, 1945

Immediate cause of death	DURATION
Carcinoma of Liver	6 Mo
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: C. F. W. Snyder M.D.
M. D. or other

Address: Cumberland Md. Date signed: 2-7-45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01282

Reg. Dist. No. 4

1. PLACE OF DEATH:

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 50 yrs.

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 457 Williams St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Rebecca P. Spiker

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widowed

6.(b) Name of husband or wife: Thomas J. Spiker

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): Aug 16 1862

8. AGE: Years	Months	Days	If less than one day
82	5	29	...hrs. ...min.

9. Birthplace: Va.

(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER — 12. Name: Marion Inc Kimmey

FATHER — 13. Birthplace: Va.

MOTHER — 14. Maiden name: Unknown

MOTHER — 15. Birthplace

16. Informant: Mrs Carleton Hanke

Address: Cumberland

17. Burial (Burial, cremation, or removal—Which?) Date thereof Feb 17 45 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland

18. Funeral director: Davis Stein Inc

Address: Cumberland.

19. Feb. 17 19 45 (Date rec'd by registrar) Walter R. Hanby M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2-15-45 19... at 3:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 11-21-44 19... to 2-15-45 19...

and that I last saw her alive on 2-13-45 19...

Immediate cause of death	DURATION
Acute myocarditis	Sudden
Due to Generalized arterio-sclerosis	1 yr.
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. C. Summers M.D. M. D. or other

Address Cumberland, Md. Date signed 2-15-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01283

CERTIFICATE OF DEATH

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS-A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 Minutes

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 23 So. Lee St (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Ashby Sponaugle

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: Mary C. Sponaugle

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 21, 1865

8. AGE: Years	Months	Days	If less than one day
79	3	3	..... hrs. ..... min.

8. Birthplace: Circleville, Pennelton Co, W. Va. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER 12. Name: Jacob Sponaugle

FATHER 13. Birthplace: West Virginia

MOTHER 14. Maiden name: Roxena Ketterman

MOTHER 15. Birthplace: West Virginia

16. Informant: Willis C. Sponaugle

Address: Rt # 1. Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/28/45 (month) (day) (year)

Cemetery or crematory: Home Cemetery

Location: Hunting Grounds, W. Va.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb. 27 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION about

20. DATE OF DEATH: February 24th., 1945, at 5:15 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ---

Date of op. .....

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE Prince H. Bowen, M.D. M. D. or other

Address: Cumberland, Maryland Date signed 2-25-45

Deputy Medical Examiner - Allegany Co.

DR. CLL. OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74)

CERTIFICATE OF DEATH

01284

Reg. Diat. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 2 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State PENNSYLVANIA County BEDFORD
City or town HYNDMAN
(If outside city or town limits, write RURAL and give nearest town)
Street No. ROUTE #1
(If rural, give LOCATION)
2.(a) If veteran, name war V

3. (a) FULL NAME
PAMELA LEE STAIR

3. (b) Social Security Number
None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
FEMALE	WHITE	SINGLE

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) May 24, 1943

8. AGE: Years	Months	Days	If less than one day
1	8		hrs. min.

9. Birthplace PENNSYLVANIA (Town, county, and state)
10. Usual occupation CHILD
11. Industry or business

FATHER
12. Name ALLEN C. STAIR
13. Birthplace PENNSYLVANIA

MOTHER
14. Maiden name ROSE MARY HAINES
15. Birthplace MARYLAND

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal? Which?) Date thereof Feb. 9 1945 (month) (day) (year)
Cemetery or Crematory Greenmount
Location Cumberland, Md.
18. Funeral director Harvey H. Zeigler
Address Hyndman, Pa.
19. Feb 9 19 45 Winter K. Trantz R.D. (Date rec'd by Registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH FEBRUARY 3 19 45, at 19:45 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19
and that I last saw h E.R. alive on 2/3/45 19

Immediate cause of death	DURATION
Acute Lymphatic Leukemia	2 mo.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John A Lapper MD M. D. or other
Address Hyndman R Date signed 2-4-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. C.L.OWENS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21a)

CERTIFICATE OF DEATH

01285

Reg. Dist. No. 4

1. PLACE OF DEATH:
County ALLEGANY
City or town CUMBERLAND,
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 8 DAYS

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State WEST VIRGINIA County MINERAL
City or town KEYSER, W.VA.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war ✓

3.(a) FULL NAME CARL FREDERICK SUTER

3.(b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
MALE	WHITE	CHILD

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 30, 1938

8. AGE: Years 6 | Months 9 | Days 8 | If less than one day ..... hrs. ..... min.

9. Birthplace WEST VIRGINIA, Keyser, Mineral Co.
(Town, county, and state)

10. Usual occupation CHILD

11. Industry or business

FATHER 12. Name CARL SUTER
13. Birthplace WEST VIRGINIA, Keyser

MOTHER 14. Maiden name PRISCILLA FLEMING
15. Birthplace WEST VIRGINIA, Rada

16. Informant MEMORIAL HOSPITAL
Address CUMBERLAND, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 14, 1945 (month) (day) (year)

Cemetery or crematory Meadow Point Cem
Location Keyser, W.Va.

18. Funeral director N. L. Rodgers Funeral Home
Address Keyser, W.Va.

19. Feb. 9, 1945 (Date rec'd by registrar) Winter L. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Feb 8th 1945, at 12.05 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 10th 1945, to Feb 8th 1945
and that I last saw h.. alive on Feb 7th 1945

	DURATION
Immediate cause of death Encephalo-Meningitis suppurative	
Due to Staphylococcic Septicemia	Dur 30
Due to	1944
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results Confirmed above diagnoses
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Owens M.D.
Address Cumberland Md Date signed Feb 8-45
M. D. or other

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS. A15

Outside of City Limits

L. Brings

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

CERTIFICATE OF DEATH

Reg. Dist. No. 012864

1. PLACE OF DEATH:
County Allegany
City or town Lonz (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 3 yrs.
Hospital, institution, or street address where death occurred: Braddock Farms
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State Md County Allegany
City or town Swanton (If outside city or town limits, write RURAL and give nearest town)
Street No. (If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Mrs Martha Virginia Sweitzer
3.(b) Social Security Number None

4. Sex Female
5. Color or race White
6.(a) Single, married, widowed, or divorced Widowed
6.(b) Name of husband or wife Jeremiah Sweitzer
6.(c) If alive, give age ... years
7. Birth date of deceased (mo., day, yr.) March 12, 1875
8. AGE: Years 69 Months 11 Days 12 If less than one day ... hrs. ... min.
9. Birthplace Swanton Garrett Co, Md (Town, county, and state)
10. Usual occupation Housework
11. Industry or business At Home
FATHER 12. Name Andrew G. Friend
13. Birthplace Friendsville, Md.
MOTHER 14. Maiden name Mahala Browning
15. Birthplace Garrett Co. Md.
16. Informant Leonard Sweitzer
Address RD 3 Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 26 1945 (month) (day) (year)
Cemetery or crematory George Cemetery
Location Swanton Md.
18. Funeral director John J. Hafer
Address Cumberland Md.
19. Feb. 26 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH February 24 1945, at 5:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 24 1945, to February 24 1945 and that I last saw her alive on February 24 1945

Immediate cause of death	DURATION
acute coronary occlusion	4 hours
Due to arteriosclerosis	many years
Due to	
Other conditions arterial hypertension	2 years

(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE L. Brings MD (M. D. or other)
Address Lonz Md Date signed 2-24-45

Dr. Briggs

MARYLAND STATE DEPARTMENT OF HEALTH

01287

2411 N. Charles St., Baltimore 45a

CERTIFICATE OF DEATH

Reg. Dist. No. 6

1. PLACE OF DEATH:

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For nowborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME Louis Frederick Tasker

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Columbia Harvey Tasker

6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): Feb. 14, 1857

8. AGE: Years	Months	Days	If less than one day
88	0	13	hrs. min.

9. Birthplace: Garrett Co. Md. (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own farm

FATHER 12. Name: Saul Tasker

FATHER 13. Birthplace: Swanton, Md.

MOTHER 14. Maiden name: Clementine Bray

MOTHER 15. Birthplace: Kitzmiller, Md.

16. Informant: Harley Tasker

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Mar 2 1945 (month) (day) (year)

Cemetery or crematory: Thomas Cem.

Location: Westernport Md.

18. Funeral director: Mrs. Ida Bond Berry

Address: Westernport, Md.

19. Mar 1 1945 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 1945, at 9:00 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 24, 1945, to Feb 27 1945

and that I last saw him alive on Feb 24 1945

Immediate cause of death	DURATION
Arteriosclerosis	2 yrs
Chronic myocarditis	"
Due to: Broncho pneumonia	2 days
Due to:	
Other conditions: Cancer lower lip	1 yr.

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Norman Reeves, M.D. M. D. or other

Address: Westernport Md Date signed 3-1-45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01288

CERTIFICATE OF DEATH

Reg. Diat. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 35 yrs.

Hospital, institution, or street address where death occurred: Miners Hospital

How long in hospital or institution? 3 months

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 57 First St.
(If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: Land Richard Taylor

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	Colored	Divorced

6.(b) Name of husband or wife: Bertha Tales

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Nov 10 - 1879

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
65	3	18		

9. Birthplace: Frostburg Allegany, Md.
(Town, county, and state)

10. Usual occupation: Retired

11. Industry or business: Brick Worker

FATHER
12. Name: Land Taylor
13. Birthplace: Atlanta Ga.

MOTHER
14. Maiden name: Maria Ross
15. Birthplace: Easton Md.

16. Informant: Clarence Cole Wife
Address: 22 Broadway, Frostburg Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 3-2-1945 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: Jacob Baker

Address: Frostburg, Md.

19. 3-2 (Date rec'd by registrar) 19 45 Mrs. Nancy H. Roe Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 28 1945, at 12:40 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb 1 1945 to Feb 28 1945 and that I last saw him alive on Feb 28 1945

Immediate cause of death	DURATION
Chronic myocarditis	?
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Lane M.D. M. D. or other

Address: Frostburg Md. Date signed: May 1945

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (127)

01289

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 80 yrs
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 314 Central Ave
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME Sally Taylor

3. (b) Social Security Number None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widowed

6.(b) Name of husband or wife: James Taylor
6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): — 1864

8. AGE: Years 80 | Months — | Days — | If less than one day: hrs. min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housework
11. Industry or business: at Home.

FATHER
12. Name: Ned Fisher
13. Birthplace: Md.

MOTHER
14. Maiden name: Mary E Coleman.
15. Birthplace: Md.

16. Informant: Harry Fisher
Address: Cumberland Md.

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Feb 6 1945 (month) (day) (year)
Cemetery or crematory: Summer Ave.
Location: Cumberland Md

18. Funeral director: Louis Stein Inc
Address: Cumberland

19. Feb 6 1945 (Date rec'd by registrar) Walter R Beatty, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 3 1945, at 7-P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 24 1945, to Feb 3 1945, and that I last saw h alive on Feb 1 1945.

	DURATION
Immediate cause of death: Nephritis Anuria	2 days
Due to: Chron Nephritis	2 years
Due to:	
Other conditions: Emph Oedema	4 mos

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: F. Alan G. Hammond M. D. or other
Address: Cumberland Md. Date signed: Feb 7 1945

VS-A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

Evidence for change of age of deceased is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (21)

CERTIFICATE OF DEATH

01290

Reg. Dist. No. 4

State File No. G 94 APR 13 1945

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 5 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 718 Gephart Drive

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Marie Jane Thiede

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct. 14, 1921

8. AGE: Years	Months	Days	If less than one day
23 24-	4	1	hrs. min.

9. Birthplace: Toledo Lucas Co Ohio (town, county, and state)

10. Usual occupation: Housework

11. Industry or business: At Home

FATHER

12. Name: Chas Fred Thiede

13. Birthplace: Chicago Ill.

MOTHER

14. Maiden name: Grace Thomas

15. Birthplace: St Marys, Ohio.

16. Informant: Donald L Cameron

Address: 718 Gephart Drive Cumb Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb 19 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Cumberland, Md.

18. Funeral director: John J Hafer

Address: Cumberland Md.

19. Feb. 19, 1945 (Date rec'd by registrar) Winter R. Trantz, M.D. Registrar

Burial 25

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 15 1945, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/10/45 19.. to 2/15/45 19..

and that I last saw h.. alive on 2/15/45 19..

Immediate cause of death	DURATION
Acute appendicitis	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operation: Acute appendicitis

Date of op. 2/10/45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: John K. Lowe M.D. M. D. or other

Address: Cumberland Md. Date signed 2/19/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01291

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 years

Hospital, institution, or street address where death occurred:

120 S. Mechanic St.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 120 S. Mechanic St.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Ethel Araminta Tretapoe

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	Widowed

6.(b) Name of husband or wife: Ernest Tretapoe

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): April 27, 1884

8. AGE:	Years	Months	Days	If less than one day
	60	10	0	...hrs. ...min.

9. Birthplace: Connemaugh Pa (Town, county, and state)

10. Usual occupation: Housekeeper

11. Industry or business: Own home

FATHER

12. Name: Robert [illegible] Moorhead

13. Birthplace: Pa.

MOTHER

14. Maiden name: Laura Shields

15. Birthplace: Pa.

16. Informant: Francis Snyder

Address: Fairview, W. Va.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: March 3, 1945 (month) (day) (year)

Cemetery or crematory: Rosehill Cemetery

Location: Cumberland, Md.

19. Funeral director: John J. Hoffman

Address: Cumberland, Md.

19. Mar. 3 1945 (Date rec'd by registrar) Walter R. Frantz, M.D. Registrar

Everheart

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb 27 1945 at 11:30 M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Jan 1935 to Feb 27 1945

and that I last saw h... alive on Feb 27 1945

Immediate cause of death	DURATION
Chr. myocarditis	10 yrs
Chr. arteriosclerosis	?
Due to Peripheral vascular disease	10 yrs
gangrene of both feet	1 mo.
Due to	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: —

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? —

23. SIGNATURE: Cyrus R. Everhart M.D. M. D. or other

Address: 36 Greene St Date signed: 3/2-45

Cumberland Md

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 77

01292

CERTIFICATE OF DEATH

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? — 40 yrs.

Hospital, Institution, or street address where death occurred: 751 Md. Ave.

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 48 Browning St.

(If rural, give LOCATION)

2.(a) If veteran, name war: —

3.(a) FULL NAME: Randa Virginia Twigg

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Aug. 5 1874

8. AGE: Years: 70 Months: 5 Days: 9 If less than one day: ..... hrs. ..... min.

9. Birthplace: Oldtown Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business:

FATHER — 12. Name: Charles H. Twigg

FATHER — 13. Birthplace: Md

MOTHER — 14. Maiden name: Susan Farlow

MOTHER — 15. Birthplace: Md

18. Informant: Charles Twigg

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Feb. 16 1945 (month) (day) (year)

Cemetery or crematory: Rose Hill Cem.

Location: Cumberland Md

18. Funeral director: Lucas Stein Inc

Address: Cumberland Md

19. Feb. 15 1945 (Date rec'd by registrar) Winter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 14, 1945, at 5:56 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15. 1945 to Feb. 14. 1945 and that I last saw her alive on Feb. 8, 1945

Immediate cause of death	DURATION
Generalized Arteriosclerosis	Years
Due to: Anaemia	Weeks
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Harry R. Twigg M. D. or other

Address: Cumberland Date signed: Feb 14 45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01293

Reg. Dist. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Rural Near Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Eastman Road

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Alvah Upole

3.(b) Social Security Number: 217-10-6569

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	married

6.(b) Name of husband or wife: Mamie George

6.(c) If alive, give age: 39 years

7. Birth date of deceased (mo., day, yr.): Feb 28, 1894

8. AGE: Years	Months	Days	If less than one day
50	11	19	hrs. min.

9. Birthplace: Mt Lake Park, Garrett Co., Md. (Town, county, and state)

10. Usual occupation: Truck Driver

11. Industry or business: Cement Products Co.

FATHER — 12. Name: Jeremiah Upole

FATHER — 13. Birthplace: Garrett Co. Md.

MOTHER — 14. Maiden name: Emma Collins

MOTHER — 15. Birthplace: W. Va.

16. Informant: Mrs Alvah Upole

Address: Eastway Road - Cumberland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb 20 1945 (month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland, Md

18. Funeral director: John J Hafer

Address: Cumberland, Md

19. Feb. 20, 1945 (Date rec'd by registrar) Wirter R. Frantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17 1945, at 11 05 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 14 1945 to February 17 1945

and that I last saw him alive on February 17 1945

	DURATION
Immediate cause of death: Apoplexy	
Due to: Hypertension	6 years
Due to: Myocarditis	6 years
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: T Bailey Hunter M.D.

Address: Cumberland Md M. D. or other

Date signed: 2/20/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Eliason

02219

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 47

CERTIFICATE OF DEATH

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: Cumberland, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Memorial Hospital
How long in hospital or institution? 1½ hours

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Near Cumberland, Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No.: McKenzie Apts., Narrows Park
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Mr. Charles Valentine

3.(b) Social Security Number: 219-03-8126

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Lily T. Welsh
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): October 29, 1870

8. AGE: Years	Months	Days	If less than one day
74	3	19	...hrs. ...min.

9. Birthplace: Maryland (Town, county, and state)
10. Usual occupation: Unable to Work
11. Industry or business

FATHER
12. Name: James Valentine
13. Birthplace: Maryland

MOTHER
14. Maiden name: Elizabeth Welsh
15. Birthplace: Maryland

16. Informant: Memorial Hospital
Address: Cumberland, Maryland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Feb. 21, 1945 (month) (day) (year)
Cemetery or crematory: Zion Memorial Cem.
Location: Cumberland, Md.
18. Funeral director: Charles L. George
Address: Cumberland, Md.

19. Feb. 21, 1945 (Date rec'd by registrar) Walter R. Franz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 17, 1945, 8:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1942 to Feb-17 1945
and that I last saw h... alive on Feb-17 1945

	DURATION
Immediate cause of death: Carcinomatosis	2 yr.
Due to: Carcinomatosis of Larynx.	3 yrs.
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operation: ... Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ... Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: ... Injured at work?

23. SIGNATURE: H. L. Eliason M. D. or other
Address: 136 Henson St. Cumberland Md. Date signed: 2/18/45

Evidence for change of year of birth of deceased is shown

FILM No. G 94 APR 13 1945

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

01294

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 30. Years

Hospital, institution, or street address where death occurred: 224. Virginia Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 228. Arch St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Lelia Brooke Wassen

3.(b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Charles E. Wassen

6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): April 1, ~~1885~~ 1888

8. AGE: Years	Months	Days	If less than one day
~~58~~ 56	10	0	....hrs. ....min.

8. Birthplace: Bridgewater, Virginia (Town, county, and state)

10. Usual occupation: House Wife

11. Industry or business: Own House

FATHER 12. Name: James Eddins

13. Birthplace: Staunton, Va.

MOTHER 14. Maiden name: Florence Peterson

15. Birthplace: Staunton, Va.

16. Informant: Charles E. Wassen

Address: 228. Arch St, Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 2/4/45 (month) (day) (year)

Cemetery or crematory: Rose Hill Mausoleum

Location: Cumberland, Md.

18. Funeral director: William H. Kight

Address: Cumberland, Md.

19. Feb 4 1945 (Date rec'd by registrar) Winter R. Hantz, M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 1st., 1945, at 3:45P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ....19...., to ....19....

and that I last saw h....alive on ....19....

	DURATION
Immediate cause of death: Coronary Occlusion	
Due to:	
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Thomas H. Bowen, M.D. M. D. or other

Address: Cumberland, Maryland Date signed: 2-3-45

Deputy Medical Examiner - Allegany Co.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (74a)

01295

CERTIFICATE OF DEATH

Reg. Diat. No. 4

1. PLACE OF DEATH:

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, institution, or street address where death occurred:

Brunswick Hotel

How long in hospital or institution? ——

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Md County: Alleg.

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 16 West Baltimore, Hammersmith Boarding House

(If rural, give LOCATION)

2.(a) If veteran, name war: ——

3.(a) FULL NAME: John Patrick Welch

3.(b) Social Security Number: 215-18-8256

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife: ——

6.(c) If alive, give age ——— years

7. Birth date of deceased (mo., day, yr.): July 3 1882

8. AGE: Years 62 | Months 7 | Days 12 | If less than one day: ——hrs. ——min.

9. Birthplace: Terra Alta W Va (Town, county, and state)

10. Usual occupation: Pipe Fitter

11. Industry or business: Tri-State Mines and Mill Supplies

FATHER — 12. Name: Thomas Welch

13. Birthplace: Ireland

MOTHER — 14. Maiden name: Margaret Ward

15. Birthplace: Ireland

16. Informant: Edward F. Mullan

Address: Cumberland Md

17. Burial (Burial, cremation, or removal? Which?) Date thereof: Feb. 17 1945 (month) (day) (year)

Cemetery or crematory: Terra Alta Cem

Location: Terra Alta W Va

18. Funeral director: Louis Stein Inc

Address: Cumberland Md

19. Feb. 15, 1945 (Date rec'd by registrar) Winter R. Hanby M.D. Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 15th., 1945 at 7 15 a.m.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from ——, 19—, to —, 19—, and that I last saw h— alive on —, 19—

Immediate cause of death	DURATION
Coronary Occlusion	
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ———

Date of op.

Autopsy results: no autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Lewis H. Larson, M.D.

M. D. or other

Address: Cumberland, Maryland Date signed: 2-15-45

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23a)

CERTIFICATE OF DEATH

D1296

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Allegany
City or town: 1 mile from Westernport
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 69 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Westernport
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 1 mile from Westernport
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: Harry Seymour Wilson

3.(b) Social Security Number:

4. Sex: Male
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Annie Netzel Wilson
6.(c) If alive, give age: 65 years
7. Birth date of deceased (mo., day, yr.): May 16, 1875
8. AGE: Years: 69 Months: 8 Days: 26 If less than one day: hrs. min.
9. Birthplace: Westernport, Alleg. Md. (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal mine
FATHER 12. Name: Jacob Wilson
FATHER 13. Birthplace: Lost River, W. Va.
MOTHER 14. Maiden name: Not known
MOTHER 15. Birthplace: " "
16. Informant: Mr. Ernest Wilson
Address: Westernport, Md.
17. (Burial, cremation, or removal) Which? Burial Date thereof: Feb. 15, 1945 (month) (day) (year)
Cemetery or crematory: Shilo
Location: Westernport, Md.
18. Funeral director: Mrs. Ray, Boak, Berry
Address: Westernport, Md.
19. Feb. 14 19 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Feb. 12, 1945 at 5:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Dec 17 1944, to Feb 12 1945
and that I last saw h.. alive on Dec 17 1944

	DURATION
Immediate cause of death: Arteriosclerosis cerebral apoplexy	2 yr 1 day
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Raymond H Reeves M.D. M. D. or other
Address: Westernport Md. Date signed: 2.14.45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

01297

CERTIFICATE OF DEATH

Reg. Dist. No. 9

1. PLACE OF DEATH:

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 172½ Mechanic Street
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Joseph Eglider

3.(b) Social Security Number: 220-03-7826

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ~ years

7. Birth date of deceased (mo., day, yr.): Apr-24-1881

8. AGE:

Years	Months	Days	If less than one day
63	9	9	hrs. min.

9. Birthplace: Paw Paw West Virginia
(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mines

FATHER
12. Name: George Yeider
13. Birthplace: Paw Paw W. Va

MOTHER
14. Maiden name: Sarah Middleton
15. Birthplace: Paw Paw W. Va.

16. Informant: George Krapf
Address: 106 W. Main St. Frostburg Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof 2/7/45
(month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Maryland

18. Funeral director: Jacob & Hafer

Address: Frostburg Maryland

19. 2-6-45 Mrs. Nancy N. Ross
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: February 4 1945 at 4 30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/2 1945, to 2/4 1945

and that I last saw h[illegible] alive on 2/2 1945

Immediate cause of death: Cardiovascular renal disease — DURATION: 2-3wks

Due to:

Due to:

Other conditions: Miners Asthma — 10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to exterior causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Hilda Jourdet Bay M.D.
M. D. or other

Address: Frostburg Md Date signed 3/5/45

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15